Nursing Assistant

Nursing Assistant

Nursing Assistant

MYRA SANDQUIST REUTER, MA, BSN, RN

Nursing Assistant Copyright © by Chippewa Valley Technical College is licensed under a Creative Commons Attribution 4.0 International License, except where otherwise noted.

Contents

Introduction 1

Preface 2

Foundational Concepts vi

Part I. Chapter 1: Communicate Professionally Within a Health Care Setting

1.1 Introduction to Communicate Professionally Within A Health Care Setting 15

1.2 The Communication Process 16

1.3 Communication Within the Health Care Team 23

1.4 Human Needs and Developmental Stages 47

1.5 Documenting and Reporting 57

1.6 Learning Activities 61

I Glossary 63

Part II. Chapter 2: Demonstrate Professionalism in the Workplace

2.1 Introduction to Demonstrate Professionalism in the Workplace 69

2.2 Ethical and Legal Responsibilities of the Nursing Assistant 70

2.3 Members of the Health Care Team and Nursing Home Structure 80

2.4 The Nursing Process 83

2.5 Scope of Practice 88

2.6 Health Care Settings 90

2.7 Job-Seeking and Keeping Skills 94

2.8 Learning Activities 97
II Glossary 98

Part III. Chapter 3: Maintain a Safe Health Care Environment

3.1 Introduction to Maintain a Safe Health Care Environment 103
3.2 Emergency Situations 104
3.3 Resident Environment 115
3.4 Body Mechanics and Safe Equipment Use 120
3.5 Skills Checklist: Making an Unoccupied Bed Checklist 124
3.6 Skills Checklist: Making an Occupied Bed 127
3.7 Learning Activities 130
III Glossary 131

Part IV. Chapter 4: Adhere to Principles of Infection Control

4.1 Introduction to Adhere to Principles of Infection Control 137
4.2 Chain of Infection 138
4.3 Defenses Against Transmission of Infection 145
4.4 Precautions Used to Prevent the Spread of Infection 149
4.5 Personal Protective Equipment (PPE) 166
4.6 Blood-borne Pathogen Standard 182
4.7 Signs and Symptoms of Infection 184
4.8 Skills Checklist: Hand Hygiene With Soap and Water 187
4.9 Skills Checklist: Hand Hygiene With Alcohol-Based Hand Sanitizer 189
4.10 Skills Checklist: Removing Gloves 191

4.11 Skills Checklist: Donning/Doffing PPE Without a Mask 193
4.12 Skills Checklist: Donning/Doffing PPE With a Mask and Face Shield or Goggles 195
4.13 Learning Activities 197
IV Glossary 198

Part V. Chapter 5: Provide for Personal Care Needs of Clients

5.1 Introduction to Provide for Personal Care Needs of Clients 205
5.2 Activities of Daily Living (ADLs) 206
5.3 Person-Centered Care 208
5.4 Pre- and Post-Procedural Steps 210
5.5 Skin Care 212
5.6 Types of Baths and Techniques 218
5.7 Assisting With Nutrition and Fluid Needs 222
5.8 Assistance With Toileting 230
5.9 Skills Checklist: Partial Bath 244
5.10 Skills Checklist: Full Bed Bath 247
5.11 Skills Checklist: Shower 250
5.12 Skills Checklist: Tub Bath 252
5.13 Skills Checklist: Shampoo 254
5.14 Skills Checklist: Foot Care 256
5.15 Skills Checklist: Nail Care 258
5.16 Skills Checklist: Skin Care 261
5.17 Skills Checklist: Back Rub 263
5.18 Skills Checklist: Perineal Care (Female) 266
5.19 Skills Checklist: Perineal Care (Male) 269

5.20 Skills Checklist: Oral Care 273
5.21 Skills Checklist: Denture Care 275
5.22 Skills Checklist: Preparing Clients for Meals and Assisting With Feeding 278
5.23 Skills Checklist: Choking Maneuver 280
5.24 Skills Checklist: Catheter Care 282
5.25 Skills Checklist: Emptying Catheter Drainage Bag 285
5.26 Skills Checklist: Assisting With a Bedpan 287
5.27 Skills Checklist: Assisting With a Urinal 289
5.28 Skills Checklist: Changing Incontinence Brief 291
5.29 Skills Checklist: Dressing A Client Who Needs Total Assistance 293
5.30 Skills Checklist: Shaving With an Electric Razor 296
5.31 Learning Activities 298
V Glossary 299

Part VI. Chapter 6: Provide for Basic Nursing Care Needs

6.1 Introduction to Provide for Basic Nursing Care Needs 305
6.2 Nutrition and Fluid Needs 307
6.3 Pain 325
6.4 Comfort Measures 331
6.5 Effects of Prescribed Routine Medications 334
6.6 End-of-Life Care 335
6.7 Postmortem Care 351
6.8 Skills Checklist: Topical Medications 352
6.9 Learning Activities 354
VI Glossary 355

Part VII. Chapter 7: Demonstrate Reporting and Documentation of Client Data

7.1 Introduction to Demonstrate Reporting and Documentation of Client Data 361
7.2 Documenting and Reporting Data 362
7.3 Recognizing Signs of Client Discomfort 364
7.4 Obtaining Vital Signs 365
7.5 Normal Ranges for Vital Signs 381
7.6 Measuring Weight and Height 384
7.7 Measuring Intake and Output 387
7.8 Skills Checklist: Oral, Tympanic, Axillary, Rectal and Temporal Temperatures 389
7.9 Skills Checklist: Pulse 394
7.10 Skills Checklist: Respirations 396
7.11 Skills Checklist: Measuring Height for Ambulatory Residents 398
7.12 Skills Checklist: Measuring Weight for Ambulatory Residents 400
7.13 Learning Activities 402
VII Glossary 403

Part VIII. Chapter 8: Utilize Principles of Mobility to Assist Clients

8.1 Introduction to Utilize Principles of Mobility to Assist Clients 409
8.2 Moving and Positioning Clients 411
8.3 Promoting Joint Mobility and Activity 424
8.4 Assisting Clients to Transfer 426
8.5 Assisting With Ambulation 439
8.6 Applying Prosthetics and Orthotics 442

8.7 Restraints and Restraint Alternatives 444
8.8 Skills Checklist: Positioning Supine to Lateral (Side-Lying) 453
8.9 Skills Checklist: Transfer From Bed to Chair With a Gait Belt 456
8.10 Skills Checklist: Transfer From Bed to Chair With Sit-to-Stand 458
8.11 Skills Checklist: Transfer From Bed to Chair With Mechanical Lift 461
8.12 Skills Checklist: Ambulation From Wheelchair 464
8.13 Learning Activities 466
VIII Glossary 467

Part IX. Chapter 9: Promote Independence Through Rehabilitation/Restorative Care

9.1 Introduction to Promote Independence Through Rehabilitation/Restorative Care 473
9.2 The Rehabilitation Process 475
9.3 Members of the Therapy Team 478
9.4 Complications of Immobility 480
9.5 Rehabilitation Versus Restorative Care 493
9.6 Promoting Independence During ADLs 496
9.7 Assisting With Sensory Deficits 499
9.8 Fall Prevention 508
9.9 Skills Checklist: Range of Motion (ROM) Exercises for the Shoulder 510
9.10 Skills Checklist: Range of Motion (ROM) for the Hip and Knee 513
9.11 Skills Checklist: Application of Compression Stockings (TED Hose) 517
9.12 Learning Activities 519
IX Glossary 520

Part X. Chapter 10: Provide Care for Clients Experiencing Acute and Chronic Health Conditions

10.1 Introduction to Provide Care for Clients Experiencing Acute and Chronic Conditions 525
10.2 History of Care for Individuals With Mental Health Disorders and Developmental Disorders 527
10.3 Caring for Clients With Developmental Disorders 531
10.4 Caring for Clients With Mental Health or Substance Use Disorders 543
10.5 Caring for Clients With Dementia 554
10.6 Promoting Nutritional Intake 572
10.7 Caregiver Role Strain 574
10.8 Learning Activities 578
X Glossary 579

Part XI. Chapter 11: Apply Knowledge of Body Systems to Client Care

11.1 Introduction to Apply Knowledge of Body Systems to Client Care 585
11.2 Cardiovascular System 586
11.3 Digestive System 595
11.4 Endocrine System 606
11.5 Integumentary System 610
11.6 Musculoskeletal System 611
11.7 Urinary System 616
11.8 Neurological System 623
11.9 Immune System 628

11.10 Respiratory System 634
11.11 Reproductive System 640
11.12 Learning Activities 645
XI Glossary 646

This textbook is an open educational resource (OER) with CC-BY licensing aligned with Wisconsin Technical College System's Nursing Assistant program (30-543-300). The Nursing Assistant program prepares students for employment as nursing assistants as well as for entry to other health-related programs. It is recognized by the Wisconsin Department of Health Services as a nurse aide training program. Upon successful completion of a Nursing Assistant program, the student is eligible to take the Wisconsin Nursing Assistant competency evaluation for inclusion on the Wisconsin Nurse Aide Registry and employment in nursing homes, hospitals, home health agencies, hospices, community based residential facilities, assisted living centers, and homes for the developmentally disabled.

Chippewa Valley Technical College created this OER with funding from the Higher Education Emergency Relief Fund (HEERF) by using Open RN workflows, remixing Open RN OER textbooks, and creating new content. The Open RN project has published five OER nursing textbooks that have been widely adopted across the United States and is funded by a $2.5 million grant from the Department of Education. More information about the Open RN project can be found at cvtc.edu/OpenRN.

This online book is free and can also be downloaded in multiple formats for offline use. The online version is required to complete interactive learning activities included in each chapter. The following video provides a quick overview of how to navigate the online version.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nurseassist/?p=4#oembed-1

Developing Author

The developing author remixed existing open educational resources and developed original content.

Myra Sandquist Reuter, MA, BSN, RN, Chippewa Valley Technical College

Editors

Kimberly Ernstmeyer, MSN, RN, CNE, CHSE, APNP-BC, Chippewa Valley Technical College
Dr. Elizabeth Christman, DNP, RN, CNE

Graphics Editor

Nic Ashman, MLIS, Librarian, Chippewa Valley Technical College

Contributors

Tammy Casey, RN, Chippewa Valley Technical College
Landon Cerny, Creative Multimedia Specialist, Chippewa Valley Technical College
Jane Flesher, MST, Proofreader, Chippewa Valley Technical College
Joshua Myers, Web Developer, Chippewa Valley Technical College
Vince Mussehl, MLIS, Open RN Lead Librarian, Chippewa Valley Technical College
Dominic Slauson, Open RN Instructional Technologist
Amanda Yule, BSN, RN, Chippewa Valley Technical College

Reviewers

Lynn Barton, MSN, RN, Oregon Coast Community College
Dr. Kathleen Capone, MS, RN, CNE, EdD, Nurses International
Tammy Casey, RN, Chippewa Valley Technical College
Tamara Davis, MSN, RN, Chippewa Valley Technical College

Marie E. Dusio, MS, RN, Madison Area Technical College
Stacey Grimm, BSN, RN, Lakeshore Technical College
Magdalena Handy, RN, South Texas College
Jill Henry, RN, Southwest Wisconsin Technical College
Dr. Amy Olson, DNP, RN, Mayo Clinic
Celee Schuch, Certified Nursing Assistant and Nursing Student, St. Catherine University
Cynthia Theys, MSN, RN, MSOLQ, Northeast Wisconsin Technical College
Gerri Van Oss, BSN, RN, Lakeshore Technical College
Dr. Nancy Whitehead, PhD, RN, APNP, Milwaukee Area Technical College
Amanda Yule, BSN, RN, Chippewa Valley Technical College

Licensing/Terms of Use

This textbook is licensed under a Creative Commons Attribution 4.0 International (CC-BY) license unless otherwise indicated, which means that you are free to:

- SHARE – copy and redistribute the material in any medium or format
- ADAPT – remix, transform, and build upon the material for any purpose, even commercially

The licensor cannot revoke these freedoms as long as you follow the license terms.

- Attribution: You must give appropriate credit, provide a link to the license, and indicate if any changes were made. You may do so in any reasonable manner, but not in any way that suggests the licensor endorses you or your use.
- No Additional Restrictions: You may not apply legal terms or technological measures that legally restrict others from doing anything the license permits.
- Notice: You do not have to comply with the license for elements of the material in the public domain or where your use is permitted by an applicable exception or limitation.

- No Warranties Are Given: The license may not give you all of the permissions necessary for your intended use. For example, other rights such as publicity, privacy, or moral rights may limit how you use the material.

Attribution

Content for this textbook was adapted from the following open educational resources. For specific reference information about what was used and/or changed in this adaptation, please refer to the footnotes at the bottom of each page of the book.

- Nursing Fundamentals by Chippewa Valley Technical College is licensed under CC BY 4.0
- Nursing Skills by Chippewa Valley Technical College is licensed under CC BY 4.0
- Nursing Pharmacology by Chippewa Valley Technical College is licensed under CC BY 4.0
- Nursing: Mental Health and Community Concepts by Chippewa Valley Technical College is licensed under CC BY 4.0
- Human Relations by LibreTexts is licensed under CC BY-NC-SA 4.0
- Microbiology by OpenStax is licensed under CC BY 4.0. Access for free at https://openstax.org/books/microbiology/pages/1-introduction
- Introduction to Infection Prevention and Control Practices for the Interprofessional Learner by Hughes, Kenmir, St-Amant, Cosgrove, & Sharpe is licensed under CC BY-NC 4.0
- Anatomy and Physiology by Boundless is licensed under CC BY-SA 4.0
- Human Nutrition by University of Hawaiʻi at Mānoa Food Science and Human Nutrition Program is licensed under CC BY 4.0
- Nursing Care at the End of Life by Lowey is licensed under CC BY-NC-SA 4.0
- StatPearls by McNeil-Masuka and Boyer is licensed under CC BY 4.0
- StatPearls by Waheed, Kudaravalli, and Hotwagner is licensed under CC BY 4.0
- Introduction to Sensation and Perception by Students of PSY 3031 and

edited by Dr. Cheryl Olman is licensed under CC BY 4.0

- Introduction to Social Work at Ferris State University by Department of Social Work is licensed under CC BY 4.0
- What is the Individuals With Disabilities Education Act? by University of Washington is licensed under CC BY-NC-SA 3.0
- Psychology by Jeffrey C. Levy is licensed under CC BY 4.0
- Understanding and Supporting Learners With Disabilities by Paula Lombardi is licensed under CC BY-NC-SA 4.0
- Abnormal Psychology by Lumen Learning is licensed under CC BY 4.0
- A Long Goodbye: Ed and Mary's Journey With Lewy Body Dementia by James Cook University is licensed under CC BY-NC-ND 4.0
- StatPearls by Khan and De Jesus is licensed under CC BY 4.0
- Opening Eyes Onto Inclusion and Diversity by Carter (Ed.) is licensed under CC BY-NC 4.0
- The Scholarship of Writing in Nursing Education: 1st Canadian Edition by Lapum, St-Amant, Hughes, Tan, Bogdan, Dimaranan, Frantzke, and Savicevic is licensed under CC BY-SA 4.0

Suggested attribution statement: Reuter-Sandquist, Myra. (2022). *Nursing Assistant* (K. Ernstmeyer and E. Christman, Eds.) by Chippewa Valley Technical College is licensed under CC BY 4.0

Foundational Concepts

Nursing assistants (NAs), also called nursing aides, are important members of the health care team. NAs work under the supervision of licensed practical/ vocational nurses (LPNs/VNs) and registered nurses (RNs).

NAs provide basic care and help patients* with activities of daily living. They typically perform the following tasks[1]:

- Clean and bathe patients
- Help patients use the toilet and dress
- Turn, reposition, and transfer patients between beds and wheelchairs
- Listen to and record patients' health concerns and report that information to nurses
- Measure patients' vital signs, such as temperature
- Serve meals and help patients eat

* Note: The terms *patient*, *client*, and *resident* are used interchangeably throughout this book to represent the people cared for by nursing assistants. Definitions of these terms are discussed in Chapter 2.6, "Health Care Settings."

Each state defines the actions and skills that nursing assistants can perform in health care facilities, also referred to as their scope of practice. Job descriptions in health care agencies also list specific expectations and duties for NAs within that facility. Depending on the NA's level of training, the facility, and the state law in which they work, nursing assistants may also dispense medication. These actions and associated skills checkoffs will be discussed throughout this book.

1. Bureau of Labor Statistics, U.S. Department of Labor. *Occupational Outlook Handbook, Nursing Assistants and Orderlies.* https://www.bls.gov/ooh/healthcare/nursing-assistants.htm

View the following YouTube video about Nursing Assistants[2]: Certified Nursing Assistant Career.

In 2020, nursing assistants were employed in 1.4 million jobs in many types of health care facilities. The largest employers of nursing assistants were as follows[3]:

- Skilled nursing facilities: 37%
- Hospitals: 30%
- Assisted-living facilities: 11%
- Home health care agencies: 6%
- Government agencies: 4%

Skilled nursing facilities (commonly referred to as "nursing homes") provide inpatient services to patients who require medical, nursing, or rehabilitative services but do not provide the level of care or treatment available in a hospital. **Assisted-living facilities** are living arrangements where people live on their own in a residential facility but additional personal care services such as meals, housekeeping, transportation, and assistance with activities of daily living are available. Residents in assisted living facilities typically pay monthly rent with additional fees for requested services. **Home health care agencies** provide skilled nursing care, physical therapy, occupational therapy, speech therapy, and personal care in an individual's home.[4] "Health care settings" are further discussed in Chapter 2.

Overall employment of nursing assistants is projected to grow eight percent from 2020 to 2030. As the baby-boom population ages, nursing assistants will

2. WVHCA. (2012, July 27). *Certified nursing assistant career* [Video]. YouTube. All rights reserved. https://youtu.be/fRjNpjxnjYo
3. Bureau of Labor Statistics, U.S. Department of Labor. *Occupational Outlook Handbook, Nursing Assistants and Orderlies*. https://www.bls.gov/ooh/healthcare/nursing-assistants.htm
4. Centers for Medicare & Medicaid Services. https://www.cms.gov

help care for an increasing number of older adults who have chronic or progressive diseases, such as heart disease and diabetes.

Client preferences and shifts in federal and state funding are also increasing the demand for home and community-based long-term care, which should lead to increased opportunities for nursing assistants in home health and community rehabilitation services.[5].

Nursing assistants may work full time or part time. Because health care facilities provide patient care at all hours, nursing assistants often work nights, weekends, and holidays.[6]

Becoming a Nursing Assistant

To become a nursing assistant, an individual must complete a state-approved education program and pass their state's competency exam. A state-approved education program includes classroom instruction on nursing assistant principles, as well as supervised clinical work. These educational programs are available in high schools, community colleges, vocational and technical schools, hospitals, and nursing homes. Nursing assistants who pass their state's competency exam are placed on a state registry. They must be on this state registry to work in a skilled nursing facility.[7]

Professional Qualities of a Nursing Assistant

As personal caregivers, nursing assistants must demonstrate professional qualities, including communication skills, compassion, patience, and physical stamina[8]:

5. Bureau of Labor Statistics, U.S. Department of Labor. *Occupational Outlook Handbook, Nursing Assistants and Orderlies.* https://www.bls.gov/ooh/healthcare/nursing-assistants.htm
6. Bureau of Labor Statistics, U.S. Department of Labor. *Occupational Outlook Handbook, Nursing Assistants and Orderlies.* https://www.bls.gov/ooh/healthcare/nursing-assistants.htm
7. Bureau of Labor Statistics, U.S. Department of Labor. *Occupational Outlook Handbook, Nursing Assistants and Orderlies*. https://www.bls.gov/ooh/healthcare/nursing-assistants.htm
8. Bureau of Labor Statistics, U.S. Department of Labor. *Occupational Outlook Handbook, Nursing Assistants and Orderlies.* https://www.bls.gov/ooh/healthcare/nursing-assistants.htm

- **Communication skills.** Nursing assistants must listen and respond to patients' concerns. They must appropriately share observed patient information with nurses and other health care workers caring for that patient. Communicating professionally in a health care setting is discussed in Chapter 1.
- **Empathy.** Nursing assistants care for people who are sick, injured, debilitated, cognitively impaired, or need assistance for other reasons. A compassionate attitude is required to do this type of work.
- **Physical stamina.** Nursing assistants spend much of their time on their feet performing tasks such as lifting or moving patients. It is important to be in good physical condition to safely perform these tasks and avoid injury to oneself or others. "Body mechanics and safe equipment use" are discussed in Chapter 3.
- **Professionalism.** Repetitive tasks of cleaning, feeding, and bathing patients can be stressful. Nursing assistants must complete these tasks with professionalism.

Nursing assistants have one of the highest rates of injuries and illnesses of all occupations from lifting and moving patients and other physically demanding tasks. Nursing assistants typically complete a brief period of on-the-job training to learn about their specific employer's equipment, policies, and procedures, as well as training in how to properly lift people to reduce the risk of injuries.[9]

Professionalism

What does professionalism mean? Being professional means delivering patient care in a manner that is ethical, respectful, competent, knowledgeable, and caring. Professional nursing assistants are committed to promoting clients' dignity and well-being, as well as displaying high

9. Bureau of Labor Statistics, U.S. Department of Labor. *Occupational Outlook Handbook, Nursing Assistants and Orderlies.* https://www.bls.gov/ooh/healthcare/nursing-assistants.htm

standards of professional behavior.[10] Good hygiene principles as a health care professional include the following:

- Wear clean scrubs every shift. Scrubs should be wrinkle-free and the correct size for a professional appearance.
- Keep your hair clean and neatly combed. Long hair should be pulled back for safety and infection control purposes.
- Keep nails clean and trimmed short. Most agencies do not permit nail polish or artificial nails. Long nails and nail polish harbor microorganisms that can spread infection.
- Get plenty of sleep before coming to work so you are alert at work.
- Wear comfortable, closed-toe shoes with nonskid soles.
- Do not wear jewelry for safety and infection control purposes. Some

10. Miller-Hoover, S. (2018). *I said what? Professionalism for the CNA.* RN.com.https://www.rn.com/featured-stories/professionalism-cna/#:~:text=Professional%20CNAs%20are%20resp[/footnote] Professional behavior includes communicating respectfully with clients, their family members, and other health care team members and introducing oneself before beginning care. It also includes being a professional employee, such as performing hand hygiene, exhibiting good personal hygiene and appearance, being dependable and on time for work, and completing one's assigned tasks in an accurate and timely manner. Professionalism includes understanding and working within one's scope of practice and being a lifelong learner to continue to provide excellent care as the health care environment changes. "Demonstrating professionalism in the workplace" is further discussed in Chapter 2.

Initiating and Concluding Personal Cares

When initiating care with a client, it is important to begin by introducing oneself. When initiating care with patients, it is essential to first provide privacy and then introduce yourself and explain what will be occurring. Providing privacy means taking actions such as talking with the patient privately in a room with the door shut. When concluding care, it is also important to ask if the resident needs anything else, as well as ensuring safety measures are in place. These routine actions are further discussed in "Pre- and Post-Procedural Steps" in Chapter 5. Before initiating care and after performing care, it is vital to perform good hand hygiene. Using hand hygiene is a simple but effective way to prevent the spread of infection when performed correctly and at the appropriate times. More details about using effective hand hygiene and preventing the spread of infection are discussed in the "Precautions Used to Prevent the Spread of Infection" in Chapter 4.

Maintaining Good Hygiene and Personal Appearance

Managing your personal hygiene with good grooming habits is a component of professionalism that contributes to patient satisfaction and prevents the spread of infection.[footnote]Miller-Hoover, S. (2018). *I said what? Professionalism for the CNA.* RN.com. https://www.rn.com/featured-stories/professionalism-cna/#:~:text=Professional%20CNAs%20are%20resp

agencies permit wedding rings.

- Do not wear perfume or strong-smelling deodorants or powders. Strong odors can cause nausea, headaches, or allergic reactions in some patients, especially if they are not feeling well.
- Follow agency policies regarding tattoos and piercings.
- Always wear your name badge while at work.
- Wear a watch with a second hand that is easily cleaned.
- Carry a pen and paper in your pocket for taking client care notes to report or document.
- Use effective coping skills to deal with stress at work, home, and school.
- Notify your supervisor if you are not feeling well.

Overview of This Book

The chapters in this book discuss the following competencies that a student must demonstrate to successfully become a certified nursing assistant:

- Chapter 1: Communicate Professionally Within a Health Care Setting
- Chapter 2: Demonstrate Professionalism in the Workplace
- Chapter 3: Maintain a Safe Health Care Environment
- Chapter 4: Adhere to Principles of Infection Control
- Chapter 5: Provide for Personal Care Needs of Clients
- Chapter 6: Provide for Basic Nursing Care Needs
- Chapter 7: Demonstrate Reporting and Documentation of Client Data
- Chapter 8: Utilize Principles of Mobility to Assist Clients
- Chapter 9: Promote Independence Through Rehabilitation/Restorative Care
- Chapter 10: Provide Care for Clients Experiencing Acute and Chronic Health Conditions
- Chapter 11: Apply Knowledge of Body Systems to Client Care

PART I

CHAPTER 1: COMMUNICATE PROFESSIONALLY WITHIN A HEALTH CARE SETTING

1.1 Introduction to Communicate Professionally Within A Health Care Setting

Learning Objectives

- Interact professionally with clients, families, and coworkers
- Display appropriate verbal and nonverbal communication skills in the health care setting
- Establish therapeutic relationships with clients and their family members
- Respond to clients exhibiting disruptive behaviors
- Respond to aggressive behavior
- Establish effective working relationships with supervisors and peers
- Demonstrate effective reporting and documentation
- Assist clients to meet spiritual needs
- Adapt care and communication to meet the psychological needs of the aging client
- Demonstrate empathy for the emotional needs and mental health of diverse clients
- Apply effective coping strategies

Effective communication is a vital skill for nursing assistants. Nursing assistants communicate professionally with patients and other health care team members throughout every shift. This chapter will review the communication process, discuss strategies for adapting communication based on the needs of the client and health care team, and introduce guidelines for documentation and reporting.

1.2 The Communication Process

Communication is a process by which information is exchanged between individuals through a common system of symbols, signs, or behavior.[1] In the health care setting, good communication is the foundation to trusting relationships that improve client outcomes. It is the gateway to providing holistic care. **Holistic care** addresses a client's physical, emotional, social, and spiritual needs.[2] The communication process involves a sender, the message, and a receiver. See Figure 1.1[3] for an illustration of the communication process.

Figure 1.1 The Communication Process

Verbal Messages

There are many aspects of the communication process that can alter the delivery and interpretation of the message. These aspects relate to the language and experience of both the sender and receiver, referred to as semantics. People typically make reference to things they are familiar with, including landmarks, popular culture, and slang. Barriers can occur even

1. Merriam-Webster. *Communication*. https://www.merriam-webster.com/dictionary/communication
2. Jasemi, M., Valizadeh, L., Zamanzadeh, V., & Keogh, B. (2017). A concept analysis of holistic care by hybrid model. *Indian Journal of Palliative Care, 23*(1), 71–80. https://doi.org/10.4103/0973-1075.197960
3. "Communication Process" by Meredith Pomietlo for Chippewa Valley Technical College is licensed under CC BY 4.0

when both parties in the conversation speak the same language. For example, if you asked a person who has never used the Internet to "Google it," they would have no idea what that means.

Nonverbal Messages

Nonverbal messages, also referred to as body language, greatly impact the conversational process. **Nonverbal communication** includes body language and facial expressions, tone of voice, and pace of the conversation. See Figure 1.2[4] for an illustration of body language communicating a message. Nonverbal communication can have a tremendous impact on the communication experience and may be much more powerful than the verbal message itself. You may have previously learned that 80% of communication is nonverbal communication. The importance of nonverbal communication during conversation has been broken down further, estimating that 55% of communication is body language, 38% is tone of voice, and 7% is the actual words spoken.[5] If the sender or receiver appears disinterested or distracted, the message or interpretation may become distorted or missed.

4. "Boulder_Worldcup_Vienna_29-05-2010a_semifinals090_Akiyo_Noguchi,_Anna_Stöhr.jpg" by Manfred Werner - Tsui is licensed under CC BY-SA 3.0
5. Thompson, J. (2011). Is nonverbal communication a numbers game? *Psychology Today.* https://www.psychologytoday.com/us/blog/beyond-words/201109/is-nonverbal-communication-numbers-game

Figure 1.2 Body Language

Health care professionals assess receivers' preferred methods of communication and individual characteristics that might influence communication and then adapt communication to meet the receivers' needs. For example, nursing assistants adapt verbal instructions for adult patients with cognitive disabilities. Although the information provided might be similar to that provided to a patient without disabilities, the way the information is provided is adapted based on the patient's developmental level. A nursing assistant may ask a cognitively intact person, "What do you want for lunch?" but adapt this information for someone with impaired cognitive function by offering a choice, such as "Do you want a sandwich or soup for lunch?" This adaptation allows the cognitively impaired patient to make a choice without being confused or overwhelmed by too many options.[6] Read more about developmental levels in the "Human Needs and Developmental Stages" section of this chapter.

Communication Styles

In addition to using verbal and nonverbal communication, people

6. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0

communicate with others using one of three styles. A **passive communicator** puts the rights of others before their own. Passive communicators tend to be apologetic or sound tentative when they speak and often do not speak up if they feel as if they are being wronged. **Aggressive communicators**, on the other hand, come across as advocating for their own rights despite possibly violating the rights of others when communicating. They tend to communicate in a way that tells others their feelings don't matter. **Assertive communicators** respect the rights of others while also standing up for their own ideas and rights when communicating. An assertive person is direct, but not insulting or offensive.[7]

Assertive communication refers to a way of conveying information that describes the facts and the sender's feelings without disrespecting the receiver's feelings. Assertive communication is different from aggressive communication because it uses "I" messages, such as "I feel…," "I understand…," or "Help me to understand…," to address issues instead of using "you" messages that can cause the receiver to feel as though they are being verbally attacked. Using assertive communication is an effective way to solve problems with patients, coworkers, and health care team members. For example, instead of using aggressive communication to say to a coworker, "You always leave your patients' rooms a mess! I dread following you on the next shift," an assertive communicator would use "I" messages. The assertive communicator might say, "I feel frustrated spending the first part of my shift decluttering patients' rooms. Help me understand the reasons why you don't empty the wastebaskets and clean up the rooms by the end of your shift."[8]

Overcoming Communication Barriers

It is important to reflect on personal factors that influence your ability to communicate with others effectively. There are many factors that can distort the message you are trying to communicate, resulting in your message not being perceived by the receiver in the way you intended. When

7. This work is a derivative of Human Relations by LibreTexts and is licensed under CC BY-NC-SA 4.0
8. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0

communicating, it is important to seek feedback that your message is clearly understood.[9] Nursing assistants must be aware of these potential barriers and try to reduce their impact by continually seeking feedback and checking understanding. Review common communication barriers in the following box.

Common Barriers to Communication in Health Care[10]

- **Jargon:** Avoid using medical terminology, complicated wording, or unfamiliar words. When communicating with patients, explain information in common language that is easy to understand. Consider any generational, geographical, or background information that may change the perception or understanding of your message.
- **Lack of attention:** It is easy to become task-centered rather than person-centered when caring for multiple residents. When entering a patient's room, remember to use preprocedural steps and mindfully focus on the person in front of you to give them your full attention. Patients should feel as if they are the center of your attention when you are with them, no matter how many other things you have going on.
- **Noise and other distractions:** Health care environments can be very noisy with people talking in the room or hallway, the TV blaring, alarms beeping, and pages occurring overhead. Create a calm, quiet environment when communicating with patients by closing doors to the hallway, reducing the volume of the TV, or moving to a

9. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0
10. SkillsYouNeed. (n.d.). *Barriers to effective communication*. https://www.skillsyouneed.com/ips/barriers-communication.html

quieter area, if possible.

- **Light:** A room that is too dark or too light can create communication barriers. Ensure the lighting is appropriate according to the patient's preference.
- **Hearing and speech problems:** If your patient has hearing or speech problems, implement strategies to enhance communication, including assistive devices such as eyeglasses, hearing aids, and any communication aids such as whiteboards, photobooks, or microphones.
- **Language differences:** If English is not your patient's primary language, it is important to seek a medical interpreter and provide written handouts in the patient's preferred language when possible. Most agencies have access to an interpreter service available by phone if they are not available on-site.
- **Differences in cultural beliefs:** The norms of social interaction vary greatly in different cultures, as well as the ways that emotions are expressed. For example, the concept of personal space varies among people from different cultural backgrounds. Some people prefer to stand very close to one another when speaking whereas others prefer a distance of a few feet. Additionally, some patients are stoic about pain whereas others are more verbally expressive when in pain.
- **Psychological barriers:** Psychological states of the sender and the receiver affect how the message is sent, received, and perceived. Consider what the receiver may be experiencing in the health care setting and what may change your delivery of your message. Being rushed, distracted, and overwhelmed are just a few things that can affect your message and its understanding.

- **Physiological barriers:** It is important to be aware of patients' potential physiological barriers when communicating. For example, if a patient is in pain, they are less likely to hear and remember what was said. If the patient is receiving pain medication, be aware these medications may alter their comprehension and response.
- **Physical barriers for nonverbal communication:** Providing information via email or text is often less effective than face-to-face communication. The inability to view the nonverbal communication associated with a message, such as tone of voice, facial expressions, and general body language, often causes misinterpretation of the message by the receiver. When possible, it is best to deliver important information to others using face-to-face communication so that nonverbal communication is included with the message.
- **Differences in perceptions and viewpoints:** Everyone has their own beliefs and perspectives and wants to feel "heard." When patients feel their beliefs or perspectives are not valued, they often become disengaged from the conversation or their plan of care. Information should be provided in a nonjudgmental manner, even if the patient's perspectives, viewpoints, and beliefs are different from your own.

1.3 Communication Within the Health Care Team

Communicating With Staff

The resident is at the center of the health care team. As a nursing assistant, most of your duties will involve interaction regarding nursing services among other CNAs, LPNs, and RNs. It is important to establish a good relationship with coworkers to ensure quality resident care. Improper communication can affect the team's ability to provide holistic care. The health care team will be discussed further in Chapter 2.

Good communication starts by respecting those you work with and using the communication skills previously discussed to grow a trusting relationship. Knowing and fulfilling your duties, documenting and reporting the completion of these duties, and functioning in a consistent and dependable manner are keys to creating strong, professional relationships within your team.

These expectations for good communication may seem challenging as an inexperienced nursing assistant, but they can be achieved by organizing your responsibilities and managing your time. This begins by arriving on time for your shift, being dressed appropriately, being prepared to start working when your shift starts, and reviewing your assigned residents' plans of care at the beginning of the shift. Items to review in the plan of care include the following:

- Resident's name and location
- Activity level and transfer status
- Assistance required for activities of daily living (ADLs)
- Diet and fluid orders (see Chapter 6 for more information)
- Elimination needs

Transfer status refers to the assistance the patient requires to be moved from one location to another, such as from the bed to a chair. **Activities of daily living (ADLs)** are daily basic tasks that are fundamental to everyday functioning (e.g., hygiene, elimination, dressing, eating, ambulating/moving).

Diet and fluid orders refer to what the resident is permitted to eat and drink. **Elimination needs** refer to assistance the resident requires for urinating and passing stool. For example, a resident requires assistance to the toilet and uses incontinence pads.

After reviewing the cares you will be providing to your assigned patients during your shift, discuss a timeline with your coworkers that meets residents' schedules and allows for the coordination of cares that require more than one caregiver. For example, one resident may require a two-person assist when transferring from the bed to the chair. Schedules for activities, treatments, labs, appointments, or other services should also be reviewed so that cares can be organized around these schedules.

As resident cares are completed, they must be documented in a timely manner and reported to nursing staff. Prepare a concise report to share with the nurse for each of your assigned clients. The report should include the time cares were provided and any observations or changes noted in the resident. Read more about documentation and reporting in the "Documenting and Reporting" section at the end of this chapter.

Communicating With the Client, Families, and Loved Ones

Therapeutic communication is a type of professional communication used with patients. It is defined as the purposeful, interpersonal, information-transmitting process through words and behaviors based on both parties' knowledge, attitudes, and skills that leads to patient understanding and participation.[1] Therapeutic communication techniques have been used by nurses since Florence Nightingale, who insisted on the importance of building trusting relationships with patients. She believed in the therapeutic healing that results from nurses' presence with patients.[2] Since then, several

1. Abdolrahimi, M., Ghiyasvandian, S., Zakerimoghadam, M., & Ebadi, A. (2017). Therapeutic communication in nursing students: A Walker & Avant concept analysis. *Electronic Physician, 9*(8), 4968–4977. https://doi.org/10.19082/4968
2. Karimi, H., & Masoudi Alavi, N. (2015). Florence Nightingale: The mother of nursing. *Nursing and Midwifery Studies, 4*(2), e29475. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4557413/

professional nursing associations have highlighted therapeutic communication as one of the most vital elements in nursing.[3] Nursing assistants also implement therapeutic communication with patients. Read an example of a nursing student effectively using therapeutic communication with patients in the following box.

An Example of Nursing Student Using Therapeutic Communication[4,5]

Figure 1.3 Attending Behaviors

Ms. Z. is a nursing student who enjoys interacting with patients. When she goes to patients' rooms, she greets them and

3. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0
4. Abdolrahimi, M., Ghiyasvandian, S., Zakerimoghadam, M., & Ebadi, A. (2017). Therapeutic communication in nursing students: A Walker & Avant concept analysis. *Electronic Physician, 9*(8), 4968–4977. https://doi.org/10.19082/4968
5. "beautiful african nurse taking care of senior patient in wheelchair" by agilemktg1 is in the Public Domain

introduces herself and her role in a calm tone. She kindly asks patients about their problems and notices their reactions. She does her best to solve their problems and answer their questions. Patients perceive that she wants to help them. She treats patients professionally by respecting boundaries and listening to them in a nonjudgmental manner. She addresses communication barriers and respects patients' cultural beliefs. She notices patients' health literacy and ensures they understand her messages and patient education. As a result, patients trust her and feel as if she cares about them, so they feel comfortable sharing their health care needs with her.

There are several components included in therapeutic communication. The health care professional uses active listening and attending behaviors to demonstrate they are interested in understanding what the patient is saying. Touch is used to professionally communicate caring, and specific therapeutic techniques are used to encourage the patient to share their thoughts, concerns, and feelings.

Active Listening and Attending Behaviors

Listening is obviously an important part of communication. A well-known phrase from a Greek philosopher named Epictetus is, "We have two ears and one mouth so we can listen twice as much as we speak." It is important to actively listen to patients and not use competitive or passive listening. **Competitive listening** occurs when we are primarily focused on sharing our own point of view instead of listening to someone else. **Passive listening** occurs when we are not interested in listening to the other person or we assume we correctly understand what the person is communicating without verifying their message. During **active listening**, we communicate verbally and nonverbally that we are interested in what the other person is saying and also verify our understanding with the speaker. For example, an active

listening technique is to restate what the person said and verify our understanding is correct, such as, "I hear you saying you are hesitant to go to physical therapy because you are afraid of falling. Is that correct?" This feedback process is the main difference between passive listening and active listening.[6]

Touch

Touch is a powerful way to professionally communicate caring and compassion if done respectfully while being aware of the patient's cultural beliefs. NAs commonly use professional touch when assessing, expressing concern, or comforting patients. For example, simply holding a patient's hand during a painful procedure can be very effective in providing comfort. See Figure 1.4[7] for an image of a nurse using touch as a therapeutic technique when caring for a patient.

6. This work is a derivative of Human Relations by LibreTexts and is licensed under CC BY-NC-SA 4.0
7. "Flickr_-_Official_U.S._Navy_Imagery_-_A_nurse_examines_a_newborn_baby..jpg" by Official Navy Page from United States of America MC2 John O'Neill Herrera/U.S. Navy is licensed in the Public Domain

Figure 1.4 Using Touch as a Therapeutic Technique

Therapeutic Communication Techniques

Therapeutic communication techniques are specific methods used to provide patients with support and information while focusing on their concerns. Nursing assistants help patients complete activities of daily living and meet goals in their plan of care based on their needs, values, skills, and abilities. It is important to recognize the autonomy of the patient to make their own decisions, maintain a nonjudgmental attitude, and avoid interrupting. Depending on the developmental stage and educational needs of the patient, appropriate terminology should be used to promote patient understanding and rapport. When using therapeutic communication, health care professionals often ask open-ended questions, repeat information, or use silence to prompt patients to process their concerns. Table 1.3a describes a variety of therapeutic communication techniques.

Table 1.3a Therapeutic Communication Techniques[8]

8. American Nurse. (n.d.). *17 therapeutic communication techniques.* https://www.myamericannurse.com/therapeutic-communication-techniques/

Therapeutic Technique	Description
Active Listening	By using nonverbal and verbal cues such as nodding and saying, "I see," health care professionals can encourage patients to continue talking. Active listening involves showing interest in what patients have to say, acknowledging that you're listening and understanding, and engaging with them throughout the conversation. General leads such as "What happened next?" can be used to guide the conversation or propel it forward.
Using Silence	At times, it's useful to not speak at all. Deliberate silence can give patients an opportunity to think through and process what comes next in the conversation. It may also give them the time and space they need to broach a new topic.
Providing Acceptance	Sometimes it is important to acknowledge a patient's message and affirm they've been heard. Acceptance isn't necessarily the same thing as agreement; it can be enough to simply make eye contact and say, "I hear what you are saying." Patients who feel their health care professionals are listening to them and taking them seriously are more likely to be receptive to care.
Giving Recognition	Recognition acknowledges a patient's behavior and highlights it. For example, saying something such as "I noticed you ate all of your breakfast today" draws attention to the action and encourages it.
Offering Self	Hospital stays can be lonely and stressful at times. When health care professionals make time to be present with their patients, it communicates they value them and are willing to give them time and attention. Offering to simply sit with patients for a few minutes is a powerful way to create a caring connection.
Giving Broad Openings/ Open-Ended Questions	Therapeutic communication is often most effective when patients direct the flow of conversation and decide what to talk about. For example, giving patients a broad opening such as "What's on your mind today?" or "What would you like to talk about?" is a good way to allow patients an opportunity to discuss what's on their mind.
Seeking Clarification	Similar to active listening, asking patients for clarification when they say something confusing or ambiguous is important. Saying something such as "I'm not sure I understand. Can you explain more to me?" helps health care professionals ensure they understand what's actually being said and can help patients process their ideas more thoroughly.
Placing the Event in Time or Sequence	Asking questions about when certain events occurred in relation to other events can help patients (and health care professionals) get a clearer sense of the whole picture. It forces patients to think about the sequence of events and may prompt them to remember something they otherwise wouldn't.

Making Observations	Making observations about the appearance, demeanor, or behavior of patients can help draw attention to areas that may indicate a problem. For example, making an observation that they haven't been eating much may lead to the discovery of a new symptom.
Encouraging Descriptions of Perception	For patients experiencing sensory issues or hallucinations, it can be helpful to ask about these perceptions in an encouraging, nonjudgmental way. Phrases such as "What do you hear now?" or "What do you see?" give patients a prompt to explain what they're perceiving without casting their perceptions in a negative light.
Encouraging Comparisons	Patients often draw upon previous experiences to deal with current problems. By encouraging them to make comparisons to situations they have coped with before, health care professionals can help patients discover solutions to their problems.
Summarizing	It is often useful to summarize what patients have said. This demonstrates you are listening and allows you to verify information. Ending a summary with a phrase such as "Does that sound correct?" gives patients explicit permission to make corrections if they're necessary.
Reflecting	Patients often ask health care professionals for advice about what they should do about particular problems. Instead of offering advice, health care professionals can ask patients to reflect on what they think they should do, which encourages them to be accountable for their own actions and helps them come up with solutions themselves.
Focusing	Sometimes during a conversation, patients mention something particularly important. When this happens, health care professionals can focus on this statement and prompt patients to discuss it further. Patients don't always have an objective perspective on what is relevant to their case, but as impartial observers, health care professionals may be able to pick out the topics on which to focus.
Confronting	Health care professionals should only use this technique after they have established trust and rapport with the client. In some situations, it can be vital to disagree with patients, present them with reality, or challenge their assumptions. Confrontation, when used correctly, can help patients break destructive routines or understand the state of their current situation.
Voicing Doubt	Voicing doubt can be a gentler way to call attention to incorrect or delusional ideas and perceptions of patients when appropriate. For example, when appropriate, a health care worker may say to a patient experiencing visual hallucinations, "I know you said you are seeing spiders on the walls, but I don't see any spiders."

Offering Hope and Humor	Because hospitals can be stressful places for patients, sharing hope that they can persevere through their current situation or lightening the mood with humor can quickly establish rapport. This technique can help move patients in a more positive state of mind. However, it is important to tailor humor to the patient's sense of humor.

In addition to the therapeutic techniques listed in Table 1.3a, health care professionals should genuinely communicate with patients with empathy. Communicating honestly, genuinely, and authentically is powerful. It opens the door to establishing true connections with others.[9] Communicating with empathy can be described as providing "unconditional positive regard." Research has demonstrated that when health care professionals communicate with empathy, there is improved patient healing, reduced symptoms of depression, and decreased medical errors.[10]

Nontherapeutic Responses

Health care professionals must be aware of potential barriers to communication. In addition to the common communication barriers discussed in the "Communication Styles" subsection of this chapter, there are several nontherapeutic responses to avoid. These nontherapeutic responses often block the patient's communication of their feelings or ideas. See Table 1.3b for a description of nontherapeutic responses.[11]

Table 1.3b Nontherapeutic Responses[12]

9. Balchan, M. (2016, February 16). *The magic of genuine communication.* http://michaelbalchan.com/communication/
10. Morrison, E. (2019). *Empathetic communication in healthcare.* EM Consulting. https://work.cibhs.org/sites/main/files/file-attachments/empathic_communication_in_healthcare_workbook.pdf?1594162691
11. Burke, A. (2021). *Therapeutic communication: NCLEX-RN.* RegisteredNursing.org. https://www.registerednursing.org/nclex/therapeutic-communication/
12. Burke, A. (2021). *Therapeutic communication: NCLEX-RN.* RegisteredNursing.org. https://www.registerednursing.org/nclex/therapeutic-communication/

Nontherapeutic Response	Description
Asking Personal Questions	Asking personal questions that are not relevant to the situation is not professional or appropriate. Don't ask questions just to satisfy your curiosity. For example, asking, "Why have you and Mary never married?" is not appropriate. A more therapeutic question would be, "How would you describe your relationship with Mary?"
Giving Personal Opinions	Giving personal opinions takes away the decision-making from the patient. Effective problem-solving must be accomplished by the patient and not the NA. For example, stating, "If I were you, I'd put your father in a nursing home" is not therapeutic. Instead, it is more therapeutic to say, "Let's talk about what options are available to your father."
Changing the Subject	Changing the subject when someone is trying to communicate with you demonstrates lack of empathy and blocks further communication. It seems to say that you don't care about what they are sharing. For example, stating, "Let's not talk about your insurance problems; it's time for your walk now" is not therapeutic. A more therapeutic response would be, "After your walk, let's talk more about your concerns about insurance so I can help find assistance for you."
Stating Generalizations and Stereotypes	Generalizations and stereotypes can threaten relationships with patients. For example, it is not therapeutic to state a stereotype like, "Older adults are always confused." It is better to focus on the patient's concern and ask, "Tell me more about your concerns about your wife's confusion."
Providing False Reassurances	When a patient is seriously ill or distressed, it is tempting to offer false hope with statements such as "You'll be fine," or "Don't worry; everything will be alright." These comments tend to discourage further expressions of feelings by the patient. A more therapeutic response would be, "It must be difficult not to know what the surgeon will find. What can I do to help?"
Showing Sympathy	Sympathy focuses on the health care professional's feelings rather than the patient. Saying "I'm so sorry about your amputation; I can't imagine losing a leg" shows pity rather than trying to help the patient cope with the situation. A more therapeutic response would be, "The loss of your leg is a major change; how do you think this will affect your life?"
Asking "Why" Questions	It can be tempting to ask a patient to explain "why" they believe, feel, or act in a certain way. However, patients and family members can interpret "why" questions as accusations and become defensive. It is best to phrase a question by avoiding the word "why." For example, instead of asking, "Why are you so upset?" it is better to rephrase the statement as, "You seem upset. What's on your mind?"

Approving or Disapproving	Health care professionals should not impose their own attitudes, values, beliefs, and moral standards on patients or family members. Judgmental messages contain terms such as “should,” “shouldn’t,” “ought to,” “good,” “bad,” “right,” or “wrong.” Agreeing or disagreeing sends the subtle message that health care professionals have the right to make value judgments about the patient’s decisions. Approving implies that the behavior being praised is the only acceptable one, and disapproving implies that the patient must meet the listener’s expectations or standards. Instead, health care professionals should help the patient explore their own beliefs and decisions. For example, it is nontherapeutic to state, “You shouldn’t schedule elective surgery; there are too many risks involved.” A more therapeutic response would be, “So you are considering elective surgery. Tell me more about it…” This response gives the patient a chance to express their ideas or feelings without fear of being judged.
Giving Defensive Responses	When patients or family members express criticism, health care professionals should actively listen. Listening does not imply agreement. To discover reasons for the patient’s anger or dissatisfaction, health care professionals should listen without criticism, avoid being defensive or accusatory, and attempt to defuse anger. For example, it is not therapeutic to state, “No one here would intentionally lie to you.” Instead, a more therapeutic response would be, “You believe people have been dishonest with you. Tell me more about what happened.” (After obtaining additional information, the health care worker may decide to follow the chain of command at the agency and report the patient’s concerns to the nurse supervisor for follow-up.)
Providing Passive or Aggressive Responses	Passive responses serve to avoid conflict or sidestep issues, whereas aggressive responses provoke confrontation. Health care workers should use assertive communication.
Arguing	Challenging or arguing against patient perceptions denies that they are real and valid to the other person. They imply that the other person is lying, misinformed, or uneducated. The skillful health care professional can provide alternative information or present reality in a way that avoids argument. For example, it is not therapeutic to state, “How can you say you didn’t sleep a wink when I heard you snoring all night long!” A more therapeutic response would be, “You don’t feel rested this morning? Let’s talk about ways to improve your sleep so you feel more rested.”

Strategies for Effective Communication

In addition to overcoming common communication barriers, using active listening and therapeutic communication techniques, and avoiding

nontherapeutic responses, there are additional strategies for promoting effective communication when providing patient-centered care. Specific questions to ask patients are as follows[13]:

- What concerns do you have about your plan of care?
- What questions do you have about your daily routine?
- Did I answer your question(s) clearly, or is there additional information you would like?

Listen closely for feedback from patients. Feedback provides an opportunity to improve patient understanding, improve the patient-care experience, and provide high-quality care. Other suggestions for effective communication with clients include the following:

- Read the care plan carefully and access any social history available. If family members or friends visit and it seems appropriate, talk with them about the client without intruding or taking up a lot of their time together. This information helps you build trust and care for the client based on their preferences and life history. For example, you might learn the resident lived on a farm most of their life and enjoyed taking care of their horses. Striking up conversations about horses is a way to build rapport with this client.
- Review any changes in routine or in the plan of care for assisting with ADLs with the client to improve understanding and participation.
- If there are questions you can't answer, be sure to report to the nurse so someone can follow up with the client. Check back with the client to ensure they have had their questions answered.
- Observe nonverbal communication from clients. Do they seem to interact during care, or is it something that they are merely tolerating and just trying to get through each day? Find an approach so they are comfortable with receiving care.

13. Smith, L. L. (2018, June 12). Strategies for effective patient communication. *American Nurse*. https://www.myamericannurse.com/strategies-for-effective-patient-communication/

Adapting Your Communication

When communicating with patients, their family members, and other caregivers, note your audience and adapt your message based on characteristics such as age, developmental level, cognitive abilities, and any communication disorders. For patients with language differences, it is vital to provide trained medical interpreters when important information is communicated.

Adapting communication according to an individual's age and developmental level includes the following strategies[14]:

- When communicating with children, speak calmly and gently. It is often helpful to demonstrate what will be done during a procedure on a doll or stuffed animal. To establish trust, try using play or drawing pictures.
- When communicating with adolescents, give freedom to make choices within established limits.
- When communicating with older adults, be aware of potential vision and hearing impairments that commonly occur and address these barriers accordingly. For example, if a patient has glasses and/or hearing aids, be sure these devices are in place before communicating.

Strategies for Communicating With Patients With Impaired Hearing, Vision, and Speech

In addition to adapting your communication to your audience, there are additional strategies to use with individuals who have impaired hearing, vision, or speech.

Impaired Hearing[15]

14. Butcher, H., Bulechek, G., Dochterman, J., & Wagner, C. (2018). *Nursing interventions classification (NIC)*. Elsevier, pp. 115-116.
15. Butcher, H., Bulechek, G., Dochterman, J., & Wagner, C. (2018). *Nursing interventions classification (NIC)*. Elsevier, pp. 115-116.

- Gain the person's attention before speaking (e.g., through touch)
- Minimize background noise
- Position yourself 2-3 feet away from the patient
- Facilitate lip-reading by facing the person directly in a well-lit environment
- Use gestures, when necessary
- Listen attentively, allowing the person adequate time to process communication and respond
- Refrain from shouting at the person
- Ask the person to suggest strategies for improved communication (e.g., speaking toward a better ear, moving to well-lit area, and speaking in a lower-pitched tone)
- Face the person directly, establish eye contact, and avoid turning away mid-sentence
- Simplify language (e.g., do not use slang but do use short, simple sentences), as appropriate
- Read the care plan for information on the preferred method of communicating (whiteboards, pictures, etc.)
- Assist the person using any devices such as hearing aids or voice amplifiers
- Report any changes to the nurse

Impaired Vision[16]

- Identify yourself when entering the person's space
- Ensure the patient's eyeglasses are cleaned and stored properly when not in use, and assist the patient in wearing them during waking hours
- Provide adequate room lighting
- Minimize glare (e.g., offer sunglasses, draw window covering, position with face away from window)
- Provide educational materials in large print as available
- Read pertinent information to the patient

16. Butcher, H., Bulechek, G., Dochterman, J., & Wagner, C. (2018). *Nursing interventions classification (NIC)*. Elsevier, pp. 115-116.

- Provide magnifying devices
- Report any changes to the nurse

Impaired Speech[17]

Some patients may have problems processing what they are hearing or in responding to questions due to dementia, brain injuries, or prior strokes. This difficulty is referred to as **aphasia**. There are different types of aphasia. People with expressive aphasia understand speech and know what they want to say, but frequently speak in short phrases that are produced with great effort. For example, they may intend to say, “I would like to go to the bathroom,” but instead the words, “Bathroom, Go,” are expressed. People with receptive aphasia often speak in long sentences, but what they say may not make sense. They are unable to understand both verbal and written language. Aphasia often causes the person to become frustrated when they cannot communicate their needs. Review the following evidence-based strategies to enhance communication with a person with impaired speech[18]:

- Modify the environment to minimize excess noise and decrease emotional distress
- Phrase questions so the patient can answer using a simple “Yes” or “No,” being aware that patients with expressive aphasia may provide automatic responses that are incorrect
- Monitor the patient for frustration, anger, depression, or other responses to impaired speech capabilities
- Provide alternative methods of speech communication (e.g., writing tablet, flash cards, eye blinking, communication board with pictures and letters, hand signals or gestures, or computer)
- Adjust your communication style to meet the needs of the patient (e.g., stand in front of the patient while speaking, listen attentively, present one idea or thought at a time, speak slowly but avoid shouting, use written

17. Butcher, H., Bulechek, G., Dochterman, J., & Wagner, C. (2018). *Nursing interventions classification (NIC)*. Elsevier, pp. 115-116.
18. Butcher, H., Bulechek, G., Dochterman, J., & Wagner, C. (2018). *Nursing interventions classification (NIC)*. Elsevier, pp. 115-116.

communication, or solicit the family's assistance in understanding the patient's speech)
- Ensure the call light is within reach
- Repeat what the client said to ensure accuracy
- Instruct the client to speak slowly
- Read the care plan for instructions from the speech therapist
- Report any changes to the nurse

Responding to Challenging Situations

Being a care provider is a very rewarding career, but it also includes dealing with challenging situations. Using strong communication techniques can de-escalate situations and put patients, loved ones, and staff at ease. It is impossible to predict what behavior you may encounter as a health care worker, but having a solid basis of communication techniques can prepare you to better handle unique situations.

Memory Impairment and Behavioral Health Issues

As a nursing assistant, you will likely encounter older adults with varying degrees of memory impairment. **Older adults** are defined as adults aged 65 years old or older.[19] Residents with memory issues often become confused and can feel overwhelmed by everyday situations. For those with impaired cognitive functioning like dementia, it may not be possible to reorient them to the current time and place or to move them on from thoughts that are not based in the current situation. Aphasia and confusion can cause frustration that can result in agitation or aggression. **Agitation** refers to behaviors that fall along a continuum ranging from verbal threats and motor restlessness to harmful aggressive and destructive behaviors. Mild agitation includes symptoms such as irritability, oppositional behavior, inappropriate language, and pacing. Severely agitated patients are at immediate risk of harming themselves or others through assaultive or self-injurious behavior, and they

19. HealthyPeople.gov. (n.d.). *Older adults*. Office of Disease Prevention and Health Promotion. https://www.healthypeople.gov/2020/topics-objectives/topic/older-adults

are capable of causing property damage.[20] **Aggression** is an act of attacking without provocation.[21] Agitation and aggression will be discussed in more detail in Chapter 10, but general guidelines to prevent aggression and agitation include the following:

- Keep the environment calm and as quiet as possible.
- Build trusting relationships by learning resident preferences and routines.
- Gather information from family members and loved ones about the patient's background and beliefs.
- Offer choices to allow the patient to communicate preferences, but do not cause them to be overwhelmed with too many decisions.
- Stick to a daily routine for ADLs, meals, and activities.
- Empathize with the resident and understand that challenging behavior is often communication of emotion due to cognitive impairment and not a choice.
- Practice validation therapy. **Validation therapy** is a method of therapeutic communication used to connect with someone who has moderate- to late-stage dementia and avoid agitation. It places more emphasis on the emotional aspect of a conversation and less on the factual content, thereby imparting respect to the person, their feelings, and their beliefs. Validation may require you to agree with a statement that has been made, even though the statement is neither true or real, because to the person with dementia, it feels both true and real.[22] For example, if the resident with dementia believes they are waiting to catch the bus and is intent on doing so, sit with them by the window as if you are waiting for a bus and continue to have interaction with them until they are no longer concerned with the bus.
- Redirect behavior if appropriate. For example, suggest alternative activities such as walking around the facility, looking at photos, listening to music, or other activities the resident enjoys.

20. ScienceDirect. (n.d.). *Agitation.* https://www.sciencedirect.com/topics/immunology-and-microbiology/agitation
21. Merriam-Webster. *Aggression.* https://www.merriam-webster.com/dictionary/aggression
22. Hoyt, J. (Ed.). (2020, January 27). *Validation therapy in dementia care.* SeniorLiving.org. https://www.seniorliving.org/health/validation-therapy/

- Focus on safety for residents experiencing delusions or hallucinations. **Delusions** are unshakable beliefs in something that isn't true or based on reality. For example, a resident may refuse to eat breakfast because they have a delusion that staff are trying to poison them. **Hallucinations** are sensing things such as visions, sounds, or smells that seem real but are not. For example, a resident may refuse to enter a room because they have hallucinations of big spiders crawling on the walls. If a patient is having delusions or hallucinations, never contradict them or tell them what they perceive isn't real. Instead, empathize with them and do whatever is possible to help them feel safe. For example, offer to move to another area or investigate what the resident is concerned about.

Dealing With Stress

The stress response is a common psychological barrier to effective communication. It can affect the message sent by the sender or the reception by the receiver. The stress response is a common reaction to life events, such as a health care worker feeling overwhelmed with tasks to complete for multiple patients or a patient feeling stressed when admitted to a hospital or receiving a new diagnosis. Symptoms of the **stress response** include irritability, sweaty palms, a racing heart, difficulty concentrating, and impaired sleep. It is important to recognize symptoms of the stress response in ourselves and our patients and use strategies to manage the stress response when communicating.

There are several stress management strategies to use to manage the stress response[23]:

- Use **relaxation breathing** to become aware of one's breathing. This technique includes taking deep breaths in through the nose and blowing it out through the mouth. This process is repeated at least three times in succession and then as often as needed throughout the day.

23. American Psychological Association. (2019, November 1). *Healthy ways to handle life's stressors.* https://www.apa.org/topics/stress/tips

- Make healthy diet choices. Avoid caffeine, nicotine, and junk food because these items can increase feelings of anxiety or being on edge.
- Make time for exercise. Exercise stimulates the release of natural endorphins that reduce the body's stress response and also helps to improve sleep.
- Get enough sleep. Set aside at least 30 minutes before going to bed to wind down from the busyness of the day. Avoid using electronic devices like cell phones before bedtime because the backlight can affect sleep.
- Use **progressive relaxation**. There are several types of progressive relaxation techniques that focus on reducing muscle tension and using mental imagery to induce calmness. Progressive relaxation generally includes the following steps:
  - Start by lying down somewhere comfortable and firm, like a rug or mat on the floor. Get yourself comfortable.
  - Relax and try to let your mind go blank. Breathe slowly, deeply, and comfortably, while gradually and consciously relaxing all your muscles, one by one.
  - Work around the body one main muscle area at a time, breathing deeply, calmly, and evenly. For each muscle group, clench the muscles tightly and hold for a few seconds, and then relax them completely. Repeat the process, noticing how it feels. Do this for each of your feet, calves, thighs, buttocks, stomach, arms, hands, shoulders, and face.

Managing Clients' and Family Members' Stress

Being cared for by strangers can feel very challenging to clients. Residents in long-term care settings have frequently experienced major physical and/or cognitive changes that caused a loss of their independence and sometimes some of their autonomy. **Autonomy** is each individual's right to self-determination and decision-making based on their unique values, beliefs, and preferences. It is important for the nursing assistant to empathize with these losses and the new reality that residents must become accustomed to when

moving into a long-term care facility. Reflect on the exercise in the following box to understand a resident's feelings during their transition:

Reflection Activity

When you wake up in the morning, imagine that you cannot get out of bed on your own. Think about putting on your call light as you need to use the restroom and having to wait until someone is available to help. As you look around the room, you see some of your belongings, but many are no longer there. The floor is clean but bare; your recliner is nearby but you can't move into it. You wish you could go to the kitchen to have coffee with your partner, but they are no longer around. You miss your pet that used to sleep with you each night. Finally, an aide arrives, and although they are friendly, it is another new face that will help you to the bathroom and with other care needs.

Clients usually become more comfortable with their new reality as they become familiar with a new routine and their new home. It is important to remember that emotions related to loneliness, feeling like a burden, and loss of independence can arise at any time. The nursing assistant can help residents adjust to their new environment in the following ways:

- Greet clients by their preferred name and introduce yourself.
- Ask clients their preferences for their care. Always communicate what you will be doing next and allow the resident to redirect or refuse care.
- Provide privacy when assisting with cares.
- Use confidentiality when documenting information or reporting to other members of the health care team.
- Treat belongings carefully and with respect and remember the client's room is their home.
- Listen to the resident and address concerns if they arise. If you cannot adequately address the resident's concerns, communicate these

concerns to the nurse or supervisor.

Family members and other loved ones may have questions and concerns about the resident's care. Read more information about managing their concerns in the following "Dealing With Conflict" section.

Dealing With Conflict

Health care professionals provide personal care at integral times in the lives of patients. The demands of caregiving and the associated rapid decision-making process can create stress for health care team members, patients, family members, and other loved ones. Managing care and making decisions can cause conflict among all involved. As a nursing assistant, it is important to be aware of your role and responsibility when managing conflict.

When a patient does not want to participate in care necessary to support their proper hygiene or health maintenance, the nursing assistant can use effective communication to encourage actions and promote desired outcomes. When a resident declines care, here are some actions the nursing assistant may use that respect their choices but allow care standards to be met:

- Re-approach the resident at a later time.
- Offer an alternative method. For example, a resident may not want to shower or take a bath but would be willing to have a full bed bath, allowing them to stay covered and warm throughout care.
- Remind the resident what may occur if care is not provided, such as higher risk of infection, open areas in the skin, odor, etc.
- Encourage as much control and independence as possible. Allow the resident to direct the process if able and offer as many choices as are appropriate.

Family members and other supports may have concerns about the plan of care for a resident. This may be due to lack of medical knowledge, little experience with the procedures of health care facilities, or a feeling of

helplessness in regard to their loved one's situation. The nursing assistant should listen to and acknowledge these concerns. Following confidentiality guidelines, interventions included in the plan of care can be discussed if the resident has permitted disclosure of this information. However, the nursing assistant should only disclose information when they have confirmed the resident has permitted disclosure. It may be beneficial for family members or others involved to discuss concerns with the nurse or unit supervisor and possibly schedule a care conference with the health care team to resolve their concerns. In this instance, the aide should understand that any anger directed at them may be a result of the situation rather than a reflection of anything they have personally done.

Conflicts among coworkers can also be addressed with assertive communication techniques. As discussed in the "Communication Styles" subsection, using assertive communication is the best approach to address workplace conflict and a respectful way to make one's viewpoints known. Communication should start between the two parties that have the conflict before involving other staff. It is best to think about the situation and develop a potential solution before approaching the coworker. Frame the situation from your perspective using "I" messages. If the situation is especially tense, it may be beneficial to allow some time between the experience and the discussion to reduce stress and think more logically about the conflict. A typical time frame is to wait one day to think logically about a conflict before addressing it, often referred to as the "24-hour Rule." If you have discussed your concerns with the coworker and offered a potential solution without any resolution in the situation, it is appropriate to notify your supervisor for additional assistance at that time. See an example of conflict resolution in the following box.

Example of Conflict Resolution

A nursing assistant becomes frustrated with a coworker who works on the previous shift when they continue to neglect to

empty the wastebaskets and tidy up the residents' rooms before the end of their shift. When it became apparent this was a pattern of behavior and not an isolated incident due to an exceedingly busy shift, the nursing assistant approached the coworker and said, "I feel frustrated when I start my shift with full wastebaskets and untidy rooms for the residents you care for. Can you help me understand why these things aren't accomplished by the end of your shift? It works for me to clean up the room when I am finished assisting the resident. That way I don't forget to come back, and the residents seem to appreciate it as well." The coworker apologized for this oversight and committed to completing these tasks before leaving at the end of their shift.

1.4 Human Needs and Developmental Stages

It is important to understand human needs and developmental stages to communicate effectively and provide holistic care.

Maslow's Hierarchy of Needs

Maslow's Hierarchy of Needs was created in 1943 by American psychologist Abraham Maslow. Maslow's theory is based on the ranking of the importance of human needs and the belief that human actions are based on motivation to meet these needs. See an illustration of Maslow's Hierarchy of Needs in Figure 1.5.[1]

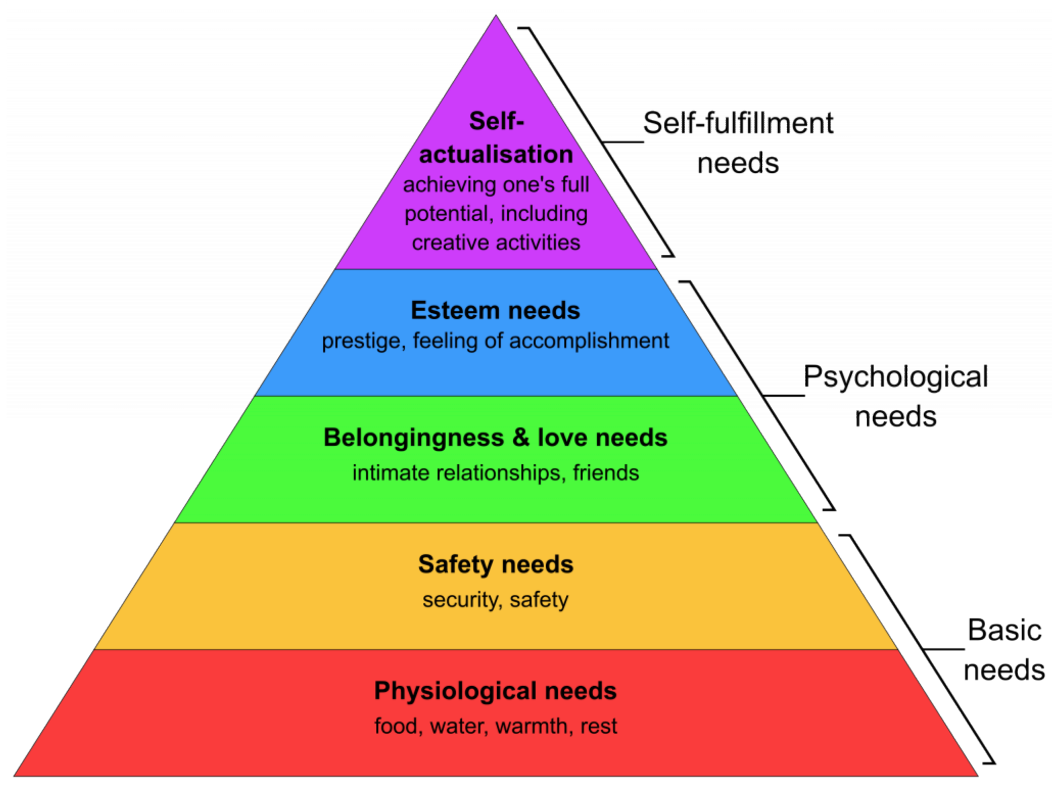


Figure 1.5 Maslow's Hierarchy of Needs

Maslow's theory states that unless the basic needs in the lower levels of the hierarchy are met, humans cannot experience the higher levels of

1. "Maslow%27s_Hierarchy_of_Needs2.svg" by Androidmarsexpress is licensed under CC.BY-SA 4.0

psychological and self-fulfillment needs. The levels of Maslow's Hierarchy of Needs have the following definitions[2]:

1. **Physiological needs:** This is the most important level with basic needs humans must have to stay alive and function, including air, food, drink, shelter, clothing, warmth, sex, and sleep.
2. **Safety needs:** People want to experience order, predictability, and control in their lives. This includes emotional security, freedom from fear, and health and well-being (such as safety against falls and injury). For new residents in a long-term care facility, this level includes becoming comfortable in familiar surroundings as opposed to feeling apprehension when experiencing a new environment.
3. **Love and belongingness:** After physiological and safety needs have been fulfilled, the third level of human needs is social and involves feelings of belongingness. **Belongingness** refers to a human emotional need for interpersonal relationships, connectedness, and being part of a group. A group may mean biological families, friends, or other supporters. It may also include physical intimacy and romantic relationships.
4. **Esteem needs:** Esteem needs include self-worth and feelings of accomplishment and respect. It includes how one views oneself and the feeling of contributing to something of importance.
5. **Self-actualization:** Self-actualization is the highest level and refers to the realization of a person's potential and self-fulfillment. This level refers to the desire to attain life goals and being truly satisfied in being the most one can be.

Maslow theorized that one cannot attain a higher level in any of these categories if the levels below are not met. For example, one is not motivated by a sense of belonging if they are focused on obtaining basic needs such as food, water, and shelter. The hierarchy is subjective because each individual determines what each level means for them. For instance, for one person, safety may mean living in the neighborhood where they grew up, whereas for

2. McLeod, S. (2020, March 20). *Maslow's hierarchy of needs*. Simply Psychology. https://www.simplypsychology.org/maslow.html

another individual it means having a daily routine. Belongingness to one person may mean being a part of a community group whereas to another it may mean having one very close friend. Self-esteem and feelings of accomplishment may be defined by one person as successfully graduating from high school, whereas to another it is defined by being able to run a mile without stopping. Self-actualization is defined by each individual and can mean things such as being a good parent, graduating from college, or achieving one's dream of becoming a nurse.

The levels of belongingness and self-actualization also include a person's spirituality and how they find meaning and purpose in life. Spirituality is often mistakenly equated with religion, but spirituality is a broader concept that includes how people seek meaning and purpose in life, as well as establish relationships with family, their community, nature, and/or a higher power.[3]

Maslow's Hierarchy of Needs is a good basis for providing holistic care and communicating with clients based on their needs and preferences. For example, in nursing, priorities of care are based on physiological needs and safety. Additionally, knowing that a newly admitted resident may have difficulty reaching a higher level of needs if their basic needs are not met is a good starting point for providing care.

Strategies that integrate Maslow's Hierarchy of Needs when providing care to residents include the following:

- Following the nursing plan of care to meet physiological needs.
- Implementing fall precautions to keep residents safe.
- Answering call lights promptly and consistently providing a calm, comfortable environment to make residents feel secure.
- Respecting residents' belongings and asking their preferences for grooming, bathing, and meals to satisfy self-esteem needs.
- Encouraging interaction among residents with similar interests to

3. Puchalski, C. M., Vitillo, R., Hull, S. K., & Reller, N. (2014). Improving the spiritual dimension of whole person care: Reaching national and international consensus. *Journal of Palliative Medicine, 17*(6), 642–656. https://doi.org/10.1089/jpm.2014.9427

promote a feeling of belongingness.
- Offering to bring residents to on-site religious activities or referring them to social services for a chaplain visit to promote self-actualization and a feeling of belongingness.

Maslow's Hierarchy of Needs can also be applied to the work environment to enhance professionalism by doing the following:

- Offering assistance to coworkers when able to promote a feeling of security and belongingness and also maintaining residents' physiological needs and safety as a team.
- Participating fully in the reporting and documentation process of the facility to meet residents' physiological and safety needs.
- Accurately following training and agency policies and procedures to encourage feelings of self-esteem in the health care worker.
- Being accountable for one's actions and job responsibilities to promote a feeling of self-actualization by meeting one's potential.

Erikson's Stages of Development

Another psychologist named Erik Erikson created a theory of psychosocial development that also describes how one's personality is developed. It theorizes there are eight stages of development based on a person's chronological age. Development occurs based on the main conflict or challenge confronted during that period of time. Each stage can create either a virtue/strength or a maladaptive tendency. Erikson proposed that those who have a stronger sense of identity from resolving these conflicts over time have fewer conflicts within themselves and with others and, subsequently, a decreased level of anxiety.[4]

Erikson's stages of development are defined as trust versus mistrust, autonomy versus shame, initiative versus guilt, industry versus inferiority,

4. This work is a derivative of StatPearls by Orenstein and Lewis and is licensed under CC BY 4.0

identity versus identity confusion, intimacy versus isolation, generativity versus stagnation, and integrity versus despair[5]:

- **Trust vs. Mistrust**

The first stage establishes trust (or mistrust) that basic needs, such as nourishment and affection, will be met. Trust is the basis of our development during infancy (birth to 12 months). Infants are dependent on their caregivers, so caregivers who are responsive and sensitive to their infant's needs help their baby to develop a sense of trust; their baby will see the world as a safe, predictable place. Unresponsive caregivers who do not meet their baby's needs can engender feelings of anxiety, fear, and mistrust; their baby may see the world as unpredictable.[6]

- **Autonomy vs. Shame**

Toddlers begin to explore their world and learn that they can control their actions and act on the environment to get results. They begin to show clear preferences for certain elements of the environment, such as food, toys, and clothing. A toddler's main task is to resolve the issue of **autonomy** versus shame and doubt by working to establish independence. For example, we might observe a budding sense of autonomy in a two-year-old child who wants to choose her clothes and dress herself. Although her outfits might not be appropriate for the situation, her input in such basic decisions has an effect on her sense of independence. If denied the opportunity to act on her environment, she may begin to doubt her abilities, which could lead to low self-esteem and feelings of shame.[7]

- **Initiative vs. Guilt**

5. This work is a derivative of Psychology 2e by OpenStax and is licensed under CC BY 4.0. Access for free at https://openstax.org/books/psychology-2e/pages/1-introduction
6. This work is a derivative of Psychology 2e by OpenStax and is licensed under CC BY 4.0. Access for free at https://openstax.org/books/psychology-2e/pages/1-introduction
7. This work is a derivative of Psychology 2e by OpenStax and is licensed under CC BY 4.0. Access for free at https://openstax.org/books/psychology-2e/pages/1-introduction

Once children reach the preschool stage (ages 3–6 years), they are capable of initiating activities and asserting control over their world through social interactions and play. By learning to plan and achieve goals while interacting with others, preschool children can master this task. Those who do will develop self-confidence and feel a sense of purpose. Those who are unsuccessful at this stage may develop feelings of guilt.[8]

- **Industry vs. Inferiority**

During the elementary school stage (ages 7–11), children begin to compare themselves to their peers to see how they measure up. They either develop a sense of pride and accomplishment in their schoolwork, sports, social activities, and family life, or they feel inferior and inadequate when they don't measure up.[9]

- **Identity vs. Identity Confusion**

In adolescence (ages 12–18), children develop a sense of self. Adolescents struggle with questions such as "Who am I?" and "What do I want to do with my life?" Along the way, most adolescents try on many different selves to see which ones fit. Adolescents who are successful at this stage have a strong sense of identity and are able to remain true to their beliefs and values in the face of problems and other people's perspectives. Teens who do not make a conscious search for identity or those who are pressured to conform to their parents' ideas for the future may have a weak sense of self and experience role confusion as they are unsure of their identity and confused about the future.[10]

- **Intimacy vs. Isolation**

8. This work is a derivative of Psychology 2e by OpenStax and is licensed under CC BY 4.0. Access for free at https://openstax.org/books/psychology-2e/pages/1-introduction
9. This work is a derivative of Psychology 2e by OpenStax and is licensed under CC BY 4.0. Access for free at https://openstax.org/books/psychology-2e/pages/1-introduction
10. This work is a derivative of Psychology 2e by OpenStax and is licensed under CC BY 4.0. Access for free at https://openstax.org/books/psychology-2e/pages/1-introduction

People in early adulthood (i.e., 20s through early 40s) are ready to share their lives with others after they have developed a sense of self. Adults who do not develop a positive self-concept in adolescence may experience feelings of loneliness and emotional isolation.[11]

- **Generativity vs. Stagnation**

When people reach their 40s, they enter a time period known as middle adulthood that extends to the mid-60s. The social task of middle adulthood is generativity versus stagnation. Generativity involves finding your life's work and contributing to the development of others, through activities such as volunteering, mentoring, and raising children. Those who do not master this task may experience stagnation, having little connection with others and little interest in productivity and self-improvement.[12]

- **Integrity vs. Despair**

The mid-60s to the end of life is a period of development known as late adulthood. People in late adulthood reflect on their lives and feel either a sense of satisfaction or a sense of failure. People who feel proud of their accomplishments feel a sense of integrity and often look back on their lives with few regrets. However, people who are not successful at this stage may feel as if their life has been wasted. They focus on what "would have," "should have," or "could have" been. They face the end of their lives with feelings of bitterness, depression, and despair.[13]

By combining Maslow's and Erickson's theories of development and motivation, we can begin to understand why some patients need more

11. This work is a derivative of Psychology 2e by OpenStax and is licensed under CC BY 4.0. Access for free at https://openstax.org/books/psychology-2e/pages/1-introduction
12. This work is a derivative of Psychology 2e by OpenStax and is licensed under CC BY 4.0. Access for free at https://openstax.org/books/psychology-2e/pages/1-introduction
13. This work is a derivative of Psychology 2e by OpenStax and is licensed under CC BY 4.0. Access for free at https://openstax.org/books/psychology-2e/pages/1-introduction

encouragement, space, or time to allow caregivers to provide assistance with their ADLs to maintain physical and emotional health.

View the following YouTube video[14] for more information about Erikson's theory of development: Erikson's Psychosocial Development | Individuals and Society.

Assisting With Spiritual Needs

When clients experience a serious illness or injury, they often grapple with the existential question, "Why is this happening to me?" This question can be a sign of spiritual distress defined as, "A state of suffering related to the inability to experience meaning in life through connections with self, others, the world, or a superior being." Spiritual well-being is a pattern of experiencing meaning and purpose in life through connectedness with self, others, art, music, literature, nature, and/or a power greater than oneself. Spirituality is often mistakenly equated with religion, but spirituality is a broader concept. Elements of spirituality include faith, meaning, love, belonging, forgiveness, and connectedness.[15] Spirituality and religion can change over a person's lifetime and vary greatly between people. Some people who are very spiritual may not belong to a specific religion.

Religion is frequently defined as an institutionalized set of beliefs and practices. Many religions have specific rules about food, religious rituals, clothing, and touching. Supporting these rules when they are meaningful part of a resident's spirituality is an effective way to support the resident and maintain a caring, professional relationship. The nursing assistant should discuss these aspects with the nurse to assure they support the plan of care

14. Desai, S. (2014, February 25). *Erikson's psychosocial development | Individuals and society | MCAT | Khan Academy* [Video]. YouTube. Licensed under CC BY-NC-SA. https://youtu.be/SIoKwUcmivk
15. Herdman, T. H., & Kamitsuru, S. (Eds.). (2018). *Nursing diagnoses: Definitions and classification, 2018-2020.* Thieme Publishers New York, pp. 365, 372-377.

for the resident and encourage other staff members to provide support. Many nursing homes and assisted living facilities offer religious or spiritual opportunities through their Activities departments.

Many hospitals, nursing homes, assisted living facilities, and hospices employ professionally trained chaplains to assist with the spiritual, religious, and emotional needs of clients, family members, and staff. In these settings, chaplains support and encourage people of all religious faiths and cultures and customize their approach to each individual's background, age, and medical condition. Chaplains can meet with any individual regardless of their belief, or lack of belief, in a higher power and can be very helpful in reducing anxiety and distress.[16] NAs may suggest chaplain services for their clients.

An important way to assist a client with their spiritual well-being is to ask them what they need to feel supported in their faith and then try to accommodate their requests, if possible. Explain that spiritual health helps the healing process. For example, perhaps they would like to speak to their clergy, spend some quiet time in meditation or prayer without interruption, or go to the on-site chapel. Many agencies have chaplains onsite that can be offered to patients as a spiritual resource.[17]

If the client or family member requests a nursing assistant to pray with them, it is acceptable to pray with them or find someone who will. Some nursing assistants may feel reluctant to pray with patients when they are asked for various reasons; they may feel underprepared, uncomfortable, or unsure if they are "allowed to." Nursing assistants, nurses, and other health care team members are encouraged to pray with their patients to support their spiritual health, as long as the focus is on the patient's preferences and beliefs, not their own preferences. Having a short, simple prayer ready that is appropriate for any faith may help a health care professional feel prepared for this situation. However, if the nursing assistant does not feel comfortable praying

16. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0
17. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0

with the patient as requested, the nurse should be notified so the chaplain can be requested to participate in prayer with the patient.[18]

It is important to support clients within their own faith tradition, but it is not appropriate for the nursing assistant to take this opportunity to attempt to persuade a patient towards a preferred religion or belief system. The role of the nursing assistant is to respect and support the client's values and beliefs, not promote the nursing assistant's values and beliefs.[19]

18. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0
19. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0

Guidelines for Documentation

Accurate documentation and reporting are vital to proper client care. **Reporting** is oral communication between care providers that follows a structured format and typically occurs at the start and end of every shift or whenever there is a significant change in the resident. **Documentation** is a legal record of patient care completed in a paper chart or electronic health record (EHR). It is also referred to as charting. Checklists and flowcharts completed in the resident's room may also become part of the paper chart. Documentation is used in a court of law to prove patient care was completed if a lawsuit is filed, with the rule of thumb being, "If it wasn't documented, it wasn't done." Documentation is also reviewed by other health care team members to provide holistic care.

Accurate documentation should follow these guidelines:

- The client's chart is confidential and should only be shared with those directly involved in care. If using paper, cover information with a blank sheet. When using technology, be sure screens are visible only to you and log out after each use. Never share security measures like passwords or PIN with anyone else.
- Document as soon as any care is completed.
- Include date, time, and signature per facility policy.
- Use facts, not opinions. An opinion is, "The resident doesn't like their food." Instead, a fact should be charted, such as, "The resident refused their meal and stated they were not hungry."
- Use measuring tools, such as a graduated cylinder or a tape measure, whenever possible to provide accurate data. If you do have to estimate, provide a comparison such as, "Drainage noted on the bandage was the size of a quarter."
- If you chart on paper, always use a black pen. If you make a mistake, draw only one line through the entry, write the word "mistaken entry," and add your initials. Do not use correction fluid or completely black out the entry.

Long-term care facilities are required to complete additional documentation called a **Minimum Data Set (MDS).** The MDS is a standardized assessment tool for all residents of long-term care facilities certified to receive reimbursement by Medicare or Medicaid. The MDS is completed by a registered nurse who reviews documentation by nursing assistants to complete some parts of the MDS. Accurate documentation is vital so that facilities are appropriately reimbursed for the services provided to clients.

The MDS nurse will review the nursing assistant's documentation pertaining to a resident's sensory abilities, specifically their communication skills, hearing, and vision. For this reason, documentation must be accurate and thorough regarding assistive devices, the amount of assistance required, and skin observations. For example, devices for communication, such as whiteboards, photo books, charts, hearing aids, or glasses, must be appropriately documented, as well as the amount of assistance required for dressing, bathing, eating, toileting, repositioning in bed, transferring, and ambulating. Skin observations made during cares should also be thoroughly documented so they can be included in MDS reporting.

- View the MDS PDF from the Centers for Medicaid and Medicare Services.

Guidelines for Reporting

Reporting client information to other nursing assistants or to a nurse for follow-up is an important part of meeting client needs and providing competent care. When providing an oral report, be mindful of confidentiality and where the report is given so no one overhears private information. Appropriate places for reporting include a closed room, a nurse's station away from resident rooms and common areas, or in a private resident's room with the door closed.

Throughout this textbook, specific information that should be documented

and reported will be noted. Generally, a nursing assistant should report any physical changes in a client that seem unusual or behavior that is out of the ordinary for that person. Examples that require immediate notification to the nurse may include the following:

- Strong odors from urine, oral care, or wounds
- Reddened, warm, or open skin areas
- Difficulty breathing or chest pain

Objective information includes information about a client that can be observed through the four senses of sight, touch, hearing, or smell. This information is referred to as **signs**. Objective information can be verified by another individual and often includes measuring tools such as a scale, thermometer, specimen cup, or graduated cylinder. An example of objective information is the client's temperature was 98.6 degrees Fahrenheit.

Subjective information is information reported to you by clients or their family members. This information is referred to as **symptoms**. It is documented by using the exact wording reported with quotation marks. An example of subjective information is the resident stating, "I have a headache."

Military Time

Military time is used to record the time care is provided and any other pertinent information for the resident. It avoids confusion between daytime and nighttime hours because it does not require a.m. or p.m. Each hour of the day has its own number from 1 to 24 and no colons are used. Beginning at 1:00 p.m., simply add 12 to the hour. For example, 1:46 p.m. is written as 1346. For morning hours up to 9:59 p.m., add a zero in front of the hour. For example, 9:24 a.m. is written as 0924. Midnight is documented as either 2400 or 0000.

When reporting in military time, morning hours are pronounced beginning with "zero" or "O." For example, 7:00 a.m. is pronounced "zero seven hundred"

or “oh seven hundred.” The time of 2:43 p.m. is pronounced “fourteen forty-three.” See Figure 1.6[1] below for conversion from civilian to military time.

Figure 1.6 Military Time

1. “Military Time Clock 3I3A0711.jpg” by Deanna Hoyord for Chippewa Valley Technical College is licensed under CC BY 4.0

1.6 Learning Activities

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=145#h5p-1

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=145#h5p-2

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=145#h5p-3

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=145#h5p-4

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=145#h5p-72

I Glossary

Active listening: Listening while communicating verbally and nonverbally that we are interested in what the other person is saying and also verifying our understanding with the speaker.

Activities of daily living (ADLs): Daily basic tasks that are fundamental to everyday functioning (e.g., hygiene, elimination, dressing, eating, ambulating/moving).

Aggression: The act of attacking without provocation.

Aggressive communicators: Individuals who come across as advocating for their own rights when communicating despite possibly violating the rights of others.

Agitation: Behaviors that fall along a continuum ranging from verbal threats and motor restlessness to harmful aggressive and destructive behaviors.

Aphasia: A condition with difficulty processing what one is hearing or responding to questions due to dementia, brain injuries, or strokes.

Assertive communication: A way of conveying information that describes the facts and the sender's feelings without disrespecting the receiver's feelings.

Assertive communicators: Individuals who respect the rights of others while also standing up for their own ideas and rights when communicating.

Autonomy: Each individual's right to self-determination and decision-making based on their unique values, beliefs, and preferences.

Belongingness: A human emotional need for interpersonal relationships, connectedness, and being part of a group.

Communication: A process by which information is exchanged between individuals through a common system of symbols, signs, or behavior.

Competitive listening: Listening that occurs when we are primarily focused on sharing our own point of view instead of listening to someone else.

Delusions: Unshakable beliefs in something that isn't true or based on reality.

Diet and fluid orders: Orders regarding what the resident is permitted to eat and drink.

Documentation: A legal record of patient care completed in a paper chart or electronic health record (EHR).

Elimination needs: Assistance the resident requires for urinating and passing stool.

Hallucinations: A condition where a person senses things such as visions, sounds, or smells that seem real but are not.

Holistic care: Health care that addresses a patient's physical, emotional, social, and spiritual needs.

Maslow's Hierarchy of Needs: A theory stating that unless basic human needs within a hierarchy are met, humans cannot experience higher levels of psychological and self-fulfillment needs.

Military time: A standard for recording time that avoids confusion between daytime and nighttime hours because each hour of the day is represented by a number ranging from 00:00 to 24:59.

Minimum Data Set (MDS): A standardized assessment tool for all residents of long-term care facilities certified to receive reimbursement by Medicare or Medicaid.

Nonverbal communication: Communication that includes body language and facial expressions, tone of voice, and pace of the conversation.

Objective information: Anything that can be observed through sight, touch, hearing, or smell, referred to as "signs." An example of objective information is the client's temperature was 98.6 degrees Fahrenheit.

Older adults: Adults aged 65 years old or older.

Passive communicator: Individuals who put the rights of others before their own when communicating.

Passive listening: Listening that occurs when we are not interested in listening to the other person or we assume we correctly understand what the person is communicating without verifying their message.

Progressive relaxation: Stress management techniques that focus on reducing muscle tension and using mental imagery to induce calmness.

Relaxation breathing: A stress management technique focused on becoming aware of one's breathing.

Reporting: Oral communication between care providers that follows a structured format and typically occurs at the start and end of every shift.

Signs: Objective information obtained through the senses of sight, hearing, smell, or touch.

Stress response: The body's response to stress that can include irritability, sweaty palms, a racing heart, difficulty concentrating, and impaired sleep.

Subjective information: Information reported by clients or their family members referred to as "symptoms." An example of subjective information is the resident stating, "I have a headache."

Symptoms: Subjective information reported by clients or their family members. Symptoms are documented by using quotes around the exact words expressed by the client or their family member. For example, the client reported, "I have a headache."

Therapeutic communication: A type of professional communication used with patients defined as the purposeful, interpersonal, information-transmitting process through words and behaviors based on both parties' knowledge, attitudes, and skills that leads to patient understanding and participation.

Transfer status: Assistance the patient requires to be moved from one location to another, such as from the bed to a chair.

Validation therapy: A method of therapeutic communication used to connect with someone who has moderate to late-stage dementia and avoid agitation.

PART II

CHAPTER 2: DEMONSTRATE PROFESSIONALISM IN THE WORKPLACE

2.1 Introduction to Demonstrate Professionalism in the Workplace

Learning Objectives

- Function within and uphold the ethical and legal responsibilities of the nursing assistant
- Carry out assignments
- Develop job-seeking and keeping skills
- Protect rights of clients
- Treat all clients respectfully regardless of social, ethnic, or religious background
- Apply strategies to cope with caregiver stress
- Differentiate the nursing assistant role in a variety of health care settings

In this chapter you will learn about professional responsibilities associated with becoming a licensed nursing assistant. Resident rights are at the forefront of providing care to ensure quality of life for dependent individuals. You will become familiar with the agencies involved in regulation of long-term care, legislative acts that uphold resident rights, and the nursing assistant scope of practice. You will gain awareness about your role within the health care team, the facility, and the nursing process, as well as the variety of health care settings in which you may work as a nursing assistant.

Ethical Responsibilities of the Nursing Assistant

Nursing assistants should treat all clients equally and with compassion and respect for their inherent dignity, worth, and unique attributes. They should promote clients' rights and safety to assist in achieving the best possible health and functioning. Read more about resident rights in the box later in this section.

As a student or a newly employed nursing assistant, you may find yourself in circumstances where you observe unethical behaviors exhibited by other agency staff. Examples of unethical behavior to avoid are as follows[1]:

- Using a personal cell phone in patient care areas
- Not responding to call lights promptly when you are available to do so
- Ignoring the phone(s) assigned to you
- Using agency computers for personal use
- Avoiding clients because of their ethnicity, beliefs, demeanors, or other individual characteristics
- Avoiding work by sitting in empty patient rooms or the break room during on-time work hours
- Accepting gifts or gratuities from clients or their family members
- Sharing clients' personal information with others who are not providing direct care
- Stealing items from clients or the health care agency

Governing Agencies

When you work as a nursing assistant, you are helping vulnerable populations. **Vulnerable populations** include patients who are children, older adults, minorities, socially disadvantaged, underinsured, or those with certain

1. Miller-Hoover, S. (2018). *I said what? Professionalism for the CNA*. RN.com. https://www.rn.com/featured-stories/professionalism-cna/#:~:text=Professional%20CNAs%20are%20responsible%2C%20trustworthy,and%20being%20a%20team%20player

medical conditions. Members of vulnerable populations often have health conditions that are exacerbated by inadequate health care.[2] As a result, there are many governing agencies involved in the care of these clients to ensure their needs are met.

Federal agencies that regulate and provide guidelines for health care include the following:

- **Centers for Medicare and Medicaid (CMS):** The CMS provides health care funding for qualifying members. Medicare is health care funding available to anyone over the age of 65, as well as those who have a permanent disability or kidney failure. There are four types of coverage that Medicare provides: care in hospitals and nursing homes (Part A); medical appointments, services, and equipment (Part B); additional services provided by private companies (Part C); and prescription drug coverage (Part D). Medicaid is health care funding available for individuals with low incomes and is provided at both the federal and state level. Both Medicare and Medicaid may cover services for resident care based on each individual's needs.[3,4]
- **Centers for Disease Control (CDC):** The CDC provides guidance for facilities related to infection and disease control.[5]
- **Food and Drug Administration (FDA):** The FDA protects public health by ensuring the safety of medications, biological products, medical devices, cosmetics, products that emit radiation, and the food supply. It also regulates tobacco products and helps the public get the accurate, science-based information they need to use medical products and foods to maintain and improve their health.[6]
- **Occupational Safety and Health Administration (OSHA):** OSHA ensures

2. Waisel, D. B. (2013). Vulnerable populations. *Current Opinion in Anaesthesiology, 26*(2), 186-192. https://doi.org/10.1097/aco.0b013e32835e8c17
3. Medicare.gov. U.S. Centers for Medicare and Medicaid Services. https://www.medicare.gov/
4. Medicaid.gov. U.S. Centers for Medicare and Medicaid Services. https://www.medicaid.gov/
5. Centers for Disease Control and Prevention. (2021, September 24). *About CDC 24-7.* https://www.cdc.gov/about/default.htm
6. U.S. Food & Drug Administration. (2018, March 28). *What we do.* https://www.fda.gov/about-fda/what-we-do

safe and healthy working conditions for workers by setting and enforcing standards and by providing training, outreach, education, and assistance.[7]

Every state has a Department of Health Services (DHS) that works with local counties, health care providers, and community partners. The DHS provides services that aid and protect the state's citizens, such as alcohol and drug abuse prevention programs, mental health programs, public health services, disability determination, implementation of long-term care, and regulation of state nursing homes, along with numerous other services.

- Read more about Wisconsin's Department of Health Services at the About the Department of Health Services (DHS) web page.

Federal Health Care Acts

In addition to government agencies, there are federal laws that directly affect health care. The **Health Insurance Portability and Accountability Act of 1996 (HIPAA)** required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge. The HIPAA security rule requires the following:

- Ensure the confidentiality, integrity, and availability of all protected health information (PHI)
- Detect and safeguard against anticipated threats to the security of the information
- Protect against anticipated impermissible uses or disclosures
- Certify compliance by their workforce

As a nursing assistant, this means that you must legally keep any information

7. Occupational Safety & Health Administration. (n.d.). *About OSHA*. United States Department of Labor. https://www.osha.gov/aboutosha

regarding the care of your clients confidential, including documentation, care plans, and shift reports. Refer to the "Guidelines for Reporting" subsection in Chapter 1 for more details about confidential reports.

- Read more about HIPAA at the CDC's Health Insurance Portability and Accountability Act of 1996 (HIPAA) web page.

The **Omnibus Reconciliation Act of 1987 (OBRA)** set forth new provisions for Medicare and Medicaid related to new standards for care in the nursing home setting. One major provision was a requirement for nurse aide training. It required that new nurse aides train for a minimum of 75 hours and pass a competency evaluation and that each state records a registry for nurse aides who have passed the competency evaluation. It also focused on improving quality of life for residents in long-term care (LTC), focusing on **patient-centered care** and meeting the preferences of each individual in making decisions regarding their care.[8] Read more about long-term care settings in the "Health Care Settings" section of this chapter. During patient-centered care, an individual's specific health needs and desired health outcomes are the driving forces behind all health care decisions. Patients are partners with the health care team members, and health care professionals treat patients not only from a clinical perspective, but also from an emotional, mental, spiritual, social, and financial perspective.[9]

The **Older Americans Act (OAA)** was passed in 1965 in response to concern by policymakers about a lack of community social services for older persons. The original legislation established authority for grants to states for community planning and social services, research and development projects, and personnel training in the field of aging. It also includes states' Long-Term Care

8. Kelly, M. (1989). The omnibus budget reconciliation act of 1987. A policy analysis. *The Nursing Clinics of North America, 24*(3), 791-794. https://pubmed.ncbi.nlm.nih.gov/2671955/
9. NEJM Catalyst. (2017, January 1). *What is patient-centered care?* Massachusetts Medical Society. https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0559

(LTC) Ombudsman programs that work to resolve problems related to the health, safety, welfare, and rights of individuals who live in LTC facilities, such as nursing homes, assisted living facilities, and other residential care communities. The OAA act requires the following of ombudsman programs[10]:

- Identify, investigate, and resolve complaints made by or on behalf of residents
- Provide information to residents about long-term services and supports
- Ensure that residents have regular and timely access to ombudsman services
- Represent the interests of residents to governmental agencies and seek administrative, legal, and other remedies to protect residents
- Analyze, comment on, and recommend changes in laws and regulations pertaining to the health, safety, welfare, and rights of residents

Resident Rights

As a health care regulator, the CMS ensures residents know and understand their rights and these rights are upheld. Resident rights are the most important aspect of providing care. It is essential for health care workers to protect the dignity of residents and enhance their quality of life. A concise list of resident rights that are protected in long-term care and other settings is described in the following box.

Resident Rights in Long-Term Care and Other Settings[11]

- Be treated with respect
- Participate in activities

10. Administration for Community Living. (2021, November 24). *Long-term care ombudsman program*. https://acl.gov/programs/Protecting-Rights-and-Preventing-Abuse/Long-term-Care-Ombudsman-Program
11. Centers for Medicare & Medicaid Services. (n.d.). *Residents' rights & quality of care*. https://www.cms.gov/nursing-homes/patients-caregivers/residents-rights-quality-care

- Be free from discrimination, restraints, abuse, and neglect
- Make complaints
- Receive proper medical care
- Make decisions regarding one's care with the involvement of family and loved ones if desired
- Have one's representative notified of care and complications
- Receive information about services and fees
- Manage one's money
- Receive privacy and proper living arrangements
- Spend time with visitors
- Receive social services
- Be protected against unfair transfers or discharges
- Have the ability to leave the facility when health status allows, either temporarily or permanently
- Create or participate in groups

These guidelines should be at the forefront of your mind with any resident interaction. It is important for NAs to remember that it can be difficult for residents to accept being dependent on a caregiver for completing their ADLs. This feeling of dependency can cause them to lose self-esteem or even lead to depression. Refer back to the exercise in the "Managing Clients' and Family Members' Stress" subsection in Chapter 1 to recall how to empathize with residents. If a resident has a request, you should make accommodations to meet their needs as appropriate. If you are unsure how to meet their request, consult with your supervising nurse. The only reason a resident preference should not be granted would be due to safety or infection control concern. For example, if a resident wants to have a candle in their room, the risk of fire would not allow this request, but an alternative would be an electric candle. If a resident wanted to use a hair dryer but their roommate could possibly burn themselves due to altered safety awareness, the facility

should work to find a secure place where the resident could use the hair dryer.

- For more information, read the Your Rights and Protections as a Nursing Home Resident PDF.

Learning Activity

- Resident rights quiz: Resident Rights Quizlet

Elder Abuse and Neglect

As discussed in the "Resident Rights" section, clients are to be free from abuse and neglect. **Elder abuse** is an intentional act, or failure to act, that causes or creates a risk of harm to someone age 60 or older. The abuse occurs at the hands of a caregiver or a person the older adult trusts. **Neglect** refers to a failure to provide care for oneself or to someone for whom you are enlisted to care. Review Table 2.2 for types of abuse and neglect and signs or symptoms that you should report to the nurse.

Table 2.2 Types of Abuse and Signs or Symptoms to Report[12,13]

12. Centers for Disease Control and Prevention. (2021, June 2). *Preventing elder abuse*. https://www.cdc.gov/violenceprevention/elderabuse/fastfact.html
13. Washington State Department of Social and Health Services. (n.d.). *Self-neglect*. https://www.dshs.wa.gov/node/2444/#signs

Type of Abuse	Definition	Signs or Symptoms
Physical	Illness, pain, injury, functional impairment, distress, or death as a result of the intentional use of physical force. This includes acts such as hitting, kicking, pushing, slapping, and burning.	Bruising, fractures, burns, or any other unexplainable injury. The abused person may isolate themselves, withdraw from conversation, or change behavior when the abuser is present.
Sexual	Forced or unwanted sexual interaction of any kind. This may include unwanted sexual contact, penetration, or noncontact acts such as sexual harassment.	Injury to genital areas, rashes, infections, bleeding or discharge from genitals, torn clothing, and behavioral changes listed under "Physical" abuse "Signs or Symptoms."
Emotional or Psychological	Verbal or nonverbal behaviors that inflict anguish, mental pain, fear, or distress on an older adult. Examples include humiliation or disrespect, verbal and nonverbal threats, control of one's actions, harassment, or isolation from other loved ones.	Depression, anxiety, loss of self-confidence or motivation, or feelings of failure.
Financial	Illegal, unauthorized, or improper use of an older adult's money, benefits, belongings, property, or assets for the benefit of someone other than the older adult.	Missing items; going without food, medications, or other necessities; or excessive use of cash if they cannot account for the spending.
Neglect	Failure to meet an older adult's basic needs, including food, water, shelter, clothing, hygiene, and essential medical care.	Weight loss, skin breakdown, infection, confusion, hallucinations, dehydration, soiled linens and clothing, odors, or poor oral care.
Self-Neglect	Lack of self-care that threatens personal health and safety, including a failure to seek help for care.	See "Signs or Symptoms" listed under "Neglect."

Nursing assistants and other health care professionals are referred to as **mandated reporters** because they are required by state law to report suspected neglect or abuse of the elderly, vulnerable adults, and children. As a caregiver, you are required to report any signs or symptoms that are suspicious for abuse or neglect to the nurse. At the time of the finding, you must stay with the resident until you can ensure that no further abuse or

neglect occurs, even if you are in a facility. If a resident reports any abuse, you are obligated to inform the nurse, charge nurse, or an administrator, regardless of the cognitive function of the person reporting so that an investigation can be performed.

The Survey Process

Each state's Department of Health Services (DHS) conducts surveys of long-term care (LTC) facilities under the guidelines provided by the CMS. Standard surveys typically occur at least one time per year. During a **survey**, DHS employees observe care provided to residents, watch preparation and serving of food, review resident care plans and facility documentation, interview residents and families, and look at every aspect of the facility. The surveyors are ensuring that all aspects of residents' physical, emotional, social, and spiritual needs are met. If you are a nurse aide being observed or interviewed, it is important to only provide facts. If you do not know the answer to a question, respond that you do not know the answer and explain that you will find an answer as soon as possible. You can offer things like, "I need to check my care plan for that information," or "I would ask the nurse for clarification," as appropriate to the question.[14]

If a problem or discrepancy is discovered during a survey, the facility receives a **citation** from the surveyors. At the end of the survey process, DHS will conduct an exit interview with the Administrator, Director of Nursing (DON), and other facility leadership. When residents are found to be at a high risk for adverse events, the surveyors will ask the facility to create a plan to correct the issues. DHS will make a return visit in a few weeks to follow up on the implementation.

DHS may also conduct a survey if they have received several complaints from residents or family members or if certain events occur such as elopement of a resident or an accident with a major injury. **Elopement** is defined as an event

14. Institute of Medicine (US), Committee on Nursing Home Regulation. (1986). *Improving the quality of care in nursing homes.* National Academies Press (US); 1986. 4, Monitoring nursing home performance. https://www.ncbi.nlm.nih.gov/books/NBK217555/

when a resident who is incapable of protecting themselves from harm is able to successfully leave the facility unsupervised and unnoticed and possibly enter into harm's way.[15]

The results of a survey must be made available to the public. They must be posted at the entrance to the facility, along with information on how to contact the ombudsmen. They are also available electronically at medicare.gov.

- Read ratings of nursing homes and survey results: Medicare.gov Provider Comparison Tool.

15. Institute of Medicine (US), Committee on Nursing Home Regulation. (1986). *Improving the quality of care in nursing homes.* National Academies Press (US); 1986. 4, Monitoring nursing home performance. https://www.ncbi.nlm.nih.gov/books/NBK217555/

2.3 Members of the Health Care Team and Nursing Home Structure

As illustrated in Figure 2.1[1] below, the resident and their family members are at the center of holistic care. We know from Chapter 1 that holistic care includes physical, emotional, social, and spiritual well-being. A holistic approach focuses on a person's wellness and not just their physical illness or condition. Each member of the health care team provides holistic care to achieve the best possible health outcomes for clients and improve their quality of life. Responsibilities of the health care team members are as follows:

- Physicians and health care providers diagnose conditions and prescribe medications and treatments.
- Nursing service members include registered nurses (RNs), licensed practical nurses/vocational nurses (LPNs/VNs), certified medical technicians (CMTs), and nursing assistants (RNAs, LNAs, CNAs). The nursing team implements nursing care plans based on the nursing process and provider orders. The nursing supervisor/charge nurse/unit manager supports the nursing staff and may assist in providing resident care or treatments. Staff/Floor nurses provide nursing care to residents. Nursing assistants perform assigned or delegated nursing tasks such as assisting with ADLs and reporting any changes in a resident's condition.
- Social Services, such as social workers and case managers, assist with emotional and personal problems, benefit coordination, and any discharge or transfer needs to other facilities.
- Therapists, such as physical therapy (PT), occupational therapy (OT), and speech therapy (ST), assist residents in recovering from an illness to return to and maintain function. Therapy roles are further outlined in Chapter 9.

1. This image is a derivative of "img4.jpg" by Branden Morton. This image is included on the basis of Fair Use.

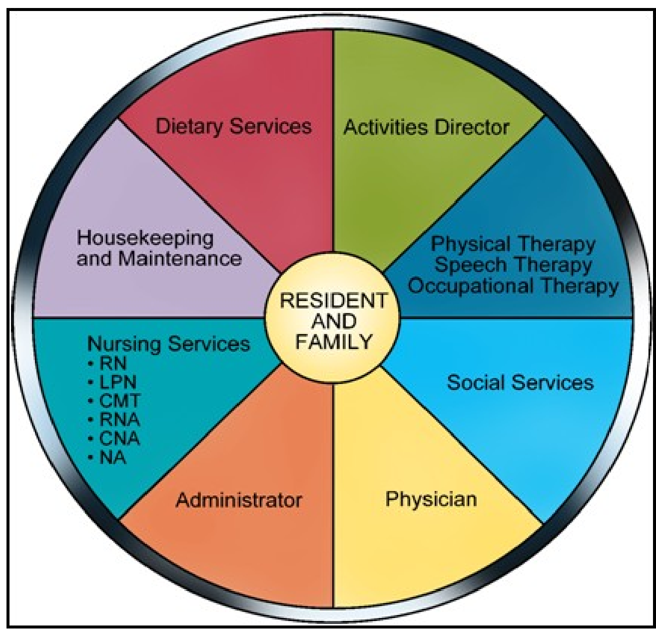


Figure 2.1 Members of the Health Care Team

Each department and member of the health care team is essential for quality resident care. Although there are a variety of certifications, skills, and abilities present within the health care team, each component is a valued resource. Your part in the team as a nursing assistant is to understand team member roles and responsibilities, coordinate with the appropriate team members when needed, and respect and support each team member's efforts. You should expect the same treatment from other health care team members regardless of their educational background, title, or job duties.

While the health care team provides care for residents in the nursing home, other departments and individuals oversee business and non-health care operations for the facility. A nursing assistant should have an understanding of the non-medical aspects necessary to meet resident needs.

Non-health care responsibilities of team members in a nursing home include the following:

- **Administrator:** Oversees federal and state regulation compliance and manages non-medical aspects of the facility, such as finance.
- **Medical Director:** Consults on medical aspects of care, such as infection control and quality of care.
- **Director of Nursing (DON):** Manages all aspects of nursing staffing,

policies, and procedures.

- **Assistant DON:** Assists with managing nursing staff and implementing policies and procedures.
- **Staff Development Coordinator (SDC):** Trains nursing employees and provides continuing education.
- **Minimum Data Set (MDS) Coordinator:** Assesses resident needs and reports to CMS for reimbursement.
- **Business Office:** Oversees billing and other financial aspects.
- **Housekeeping and Maintenance:** Maintains the facility and equipment and keeps the environment clean and safe.
- **Activities Director:** Oversees any activities staff members provide and plans events for resident enjoyment related to hobbies or interests.
- **Dietary Director:** Oversees dietary staff to deliver nutritional and fluid needs of residents.

See Figure 2.2[2] for an illustration of the general structure of a LTC facility.

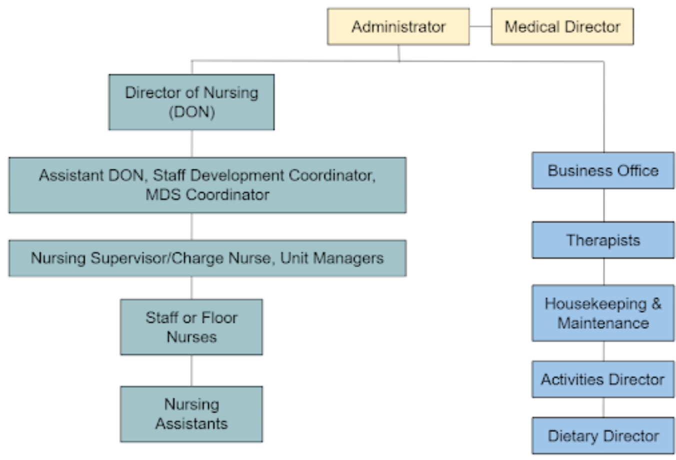


Figure 2.2 General Structure of a LTC Facility

2. "General Structure of a LTC Facility" by Myra Sandquist-Reuter for Chippewa Valley Technical College is licensed under CC BY 4.0

2.4 The Nursing Process

The **nursing process** is a critical thinking model based on a systematic approach to patient-centered care that nurses use to perform clinical reasoning and make clinical judgments when providing patient care. The nursing process is based on the Standards of Professional Nursing Practice established by the American Nurses Association (ANA). These standards are authoritative statements of the actions and behaviors that all registered nurses, regardless of role, population, specialty, and setting, are expected to perform competently.[1] The mnemonic **ADOPIE** is an easy way to remember the ANA Standards and the nursing process, with each letter referring to the six components of the nursing process: Assessment, Diagnosis, Outcomes Identification, Planning, Implementation, and Evaluation. See an illustration of the cyclical nursing process in Figure 2.3.[2]

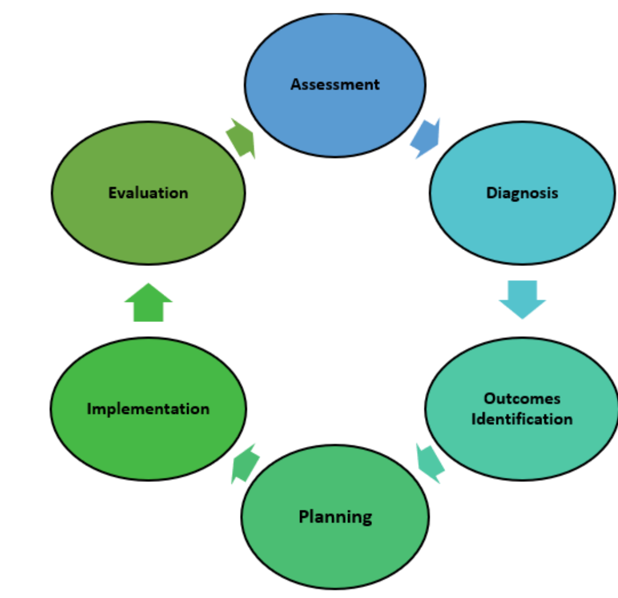


Figure 2.3 The Nursing Process

Assessment

The Assessment component of the nursing process is defined as, "The registered nurse collects pertinent data and information relative to the health

1. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.
2. "The Nursing Process" by Kim Ernstmeyer at Chippewa Valley Technical College is licensed under CC BY 4.0

care consumer's health or the situation."[3] A nursing assessment includes physiological data, as well as psychological, sociocultural, spiritual, economic, and lifestyle data. Nursing assistants should observe and report things to the nurse that they notice when providing care, such as reddened or open skin, confusion, increased swelling, or reports of pain.[4]

Diagnosis

The Diagnosis phase of the nursing process is defined as, "The registered nurse analyzes the assessment data to determine actual or potential diagnoses, problems, and issues."[5] A nursing diagnosis is the nurse's clinical judgment about the client's response to actual or potential health conditions or needs. Nursing diagnoses are the basis for the nursing care plans and are different than medical diagnoses.[6]

Outcomes Identification

The Outcomes Identification phase of the nursing process is defined as, "The registered nurse identifies expected outcomes for a plan individualized to the health care consumer or the situation."[7] The nurse sets measurable and achievable short- and long-term goals and specific outcomes in collaboration with the patient based on their assessment data and nursing diagnoses.[8] Nurses may communicate expected outcomes to nursing assistants, such as, "The client will walk at least 100 feet today."

3. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.
4. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0
5. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.
6. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0
7. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.
8. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0

Planning

The Planning phase of the nursing process is defined as, "The registered nurse develops a collaborative plan encompassing strategies to achieve expected outcomes." Assessment data, nursing diagnoses, and goals are used to select evidence-based nursing interventions customized to each patient's needs and concerns. Goals and nursing interventions are documented in the patient's nursing care plan so that nurses, as well as other health professionals, have access to it for continuity of care.[9]

Nursing Care Plans

Nursing care plans are part of the Planning step of the nursing process. A nursing care plan is a type of documentation created by registered nurses (RNs) that describes the individualized planning and delivery of nursing care for each specific patient using the nursing process. **Nursing care plans** guide the care provided to each patient across shifts so care is consistent among health care personnel. Some nursing interventions can be assigned or delegated to licensed practical nurses (LPNs) or nursing assistants with the RN's supervision.[10] Although nursing assistants do not create or edit care plans, they review this document to know what care should be provided to each client within their scope of practice.

Implementation

The Implementation phase of the nursing process is defined as, "The nurse implements the identified plan."[11] Nursing interventions are implemented or delegated with supervision according to the care plan to assure continuity of care across multiple nurses and health professionals caring for the patient. Interventions are also documented in the patient's medical record as they are

9. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0
10. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0
11. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

completed.[12] The nursing assistant's largest responsibility during the nursing process is safely implementing their delegated interventions in the nursing care plan.

Evaluation

The Evaluation phase of the nursing process is defined as, "The registered nurse evaluates progress toward attainment of goals and outcomes."[13] During evaluation, nurses assess the patient and compare the findings against the initial assessment to determine the effectiveness of the interventions and overall nursing care plan. Both the patient's status and the effectiveness of the nursing care must be continuously evaluated and modified as needed. To assist the nurse in evaluation, nursing assistants must report any changes in patient condition or new observations related to new interventions. Because nursing assistants spend the most time with the residents, it is important to communicate with the nurse if asked to implement an intervention that is known to be ineffective with a resident so a different, more effective alternative can be identified.

Benefits of Using the Nursing Process

Using the nursing process has many benefits for all members of the health care team. The benefits of using the nursing process include the following[14]:

- Promotes quality patient care
- Decreases omissions and duplications
- Provides a guide for all staff involved to provide consistent and responsive care
- Encourages collaborative management of a patient's health care problems

12. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0
13. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.
14. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0

- Improves patient safety
- Improves patient satisfaction
- Identifies a patient's goals and strategies to attain them
- Increases the likelihood of achieving positive patient outcomes
- Saves time, energy, and frustration by creating a care plan or path to follow

2.5 Scope of Practice

Scope of practice is defined as services that a trained health professional is deemed competent to perform and permitted to undertake according to the terms of their state professional license.[1] Different states have some variability in what nursing assistants can legally perform based on their licensure. It is important to check state DHS regulations to know exactly what skills and care you are able to legally provide as a nurse aide.

The CMS defines acceptable scope of practice for nursing aides at the federal level. Federal regulation 42 CFR § 483 lists nine tasks that are allowable by each state. These tasks are as follows[2]:

- Personal care skills
- Safety/emergency procedures
- Basic nursing skills
- Infection control
- Communication and interpersonal skills
- Care of cognitively impaired residents
- Basic restorative care
- Mental health and social service needs
- Residents' rights

As you learned in the "Nursing Process" section of this chapter, many tasks in the Implementation phase can be assigned or delegated by the registered nurse (RN) to the nurse aide. To keep you and your residents safe, use the **4 S's** to verify that you are performing within your scope of practice when accepting delegated or assigned tasks: **S**cope, **S**upervision, **S**afety, and **S**upplies. It is important that you ask yourself these questions before performing any cares for a resident:

1. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0
2. McMullen, T. L., Resnick, B., Chin-Hansen, J., Geiger-Brown, J. M., Miller, N., & Rubenstein, R. (2015). Certified nurse aide scope of practice: State-by-state differences in allowable delegated activities. *Journal of the American Medical Directors Association, 16*(1), 20-24. https://doi.org/10.1016/j.jamda.2014.07.003

- **Scope:** Is this task within my scope of practice as defined by my state licensure? If it is a skill or task that you did not perform for evaluation by your instructor during your nursing assistant course, it may not be legal for you to carry out under your licensure. However, some states allow facilities to provide additional training on skills to improve resident care.
- **Supervision:** Do I have supervision available? Each task delegated to you must be clear and supervised. If you are unsure of exactly what you need to perform, you should have an RN supervisor to whom you can direct questions. Supervision can be in person or via telephone.
- **Safety:** Am I safe to perform the task? Patient safety is vital. Even though you may have competently demonstrated a skill when you took your certification course, there may be tasks that you do not perform consistently depending on your care setting. For example, if you haven't recently used a mechanical lift, you may need additional training before you can safely perform this transfer technique with a resident.
- **Supplies:** Do I have the supplies I need? If you do not have the proper equipment needed for the task, it is unsafe to perform it. Supplies may include personal protective equipment (PPE) for infection control, transfer equipment and mobility aids, or personal items needed for resident grooming and hygiene.

2.6 Health Care Settings

Caregivers who provide assistance in activities of daily living (ADLs) work in a variety of settings. When an individual is no longer able to independently care for oneself, the level of care needed is what determines where they reside. For example, an individual who is able to perform most of their ADLs but needs assistance with meals and laundry may live in an assisted living facility, but someone who needs more assistance with daily ADLs may live in a nursing home. As you become more familiar with health care delivery, you will discover what type of setting will be the best fit for you. Some settings require licensure for nurse aides while others will provide training at the agency level. Table 2.6 outlines the different types of settings where health care can be delivered. Terms such as *patients*, *clients*, *residents*, and *members* are used interchangeably for people for whom nursing assistants provide care. In general, people receiving care in hospitals are referred to as "patients," people who live long-term care facilities are referred to as "residents," and people receiving outpatient care are often referred to as a "clients" or "members."

Table 2.6 Health Care Settings

Care Setting	Type of Care Provided	Typical Patient	Room Environment	What are Users Called?	Who Provides ADLs?
Hospital	24-hour care is provided with access to physicians and other providers, RNs, speech therapists, physical therapists, occupational therapists, respiratory therapists, social workers, registered dietitians, and chaplains for spiritual care. Hospitals provide acute and specialty care for patients, as well as emergency and urgent care. Some hospitals provide home health and hospice services. Larger hospitals provide various types of labs and diagnostic tests on site.	Anyone with emergent or urgent health care concerns is appropriate to be served in the hospital setting.	Designed for short stays with sterile and clean environments. Rooms are typically made for one patient and contain multiple pieces of medical equipment to avoid HIPAA and infection control concerns. Many disposable or one-time use items are used to avoid cross-contamination.	Patients	Patient Care Assistants (PCAs) or Certified Nursing Assistants (CNAs); licensure is required.

Long-term Care (LTC) or Nursing Home (NH)	24-hour skilled care is provided for people who are no longer eligible for hospital care but are unable to care for themselves at home. An RN is always on site. Residents may be admitted due to physical limitations in mobility, management of chronic conditions or medication, or both.	Typically, older adults with chronic conditions such as physical disabilities, heart disease, prior strokes, diabetes, history of major fractures, or are otherwise unsafe at home.	A long-term care facility, commonly referred to as nursing home or rehabilitation center, is where a person lives. The facility typically has both private and shared rooms, and residents are encouraged to have their own belongings. Rooms are accessible for various mobility needs but are more homelike than a hospital setting.	Residents	Certified Nursing Assistants (CNAs); licensure is required at facilities that are funded by Medicare and Medicaid.
Assisted Living	Care is provided that can be scheduled, such as medication assistance, grooming, showering, meal preparation, cleaning, and laundry. On-demand care, such as assistance with toileting or getting from one place to another, is not included.	Typically, residents are 65 years or older and are more independent than in other LTC facilities. They are medically stable but need some oversight for safety and home maintenance. As their assistance needs change, they can be moved to a different area if necessary.	Each room is like an apartment with a small kitchen and entry doors that lock.	Residents	Daily Living Assistants (DLAs) or CNAs; licensure is not required.

Group Home/ Adult Family Home	Provides daily care and maintenance with mostly an oversight on safety.	Typically, adults with developmental disabilities or moderate dementia, or those recovering from substance use disorders.	Residents have a bedroom and access to the whole house. Each state provides a maximum capacity per house, but group homes typically have 4-6 residents.	Residents or clients	Daily Living Assistants (DLAs) or CNAs; licensure is not required.
Home Health	Any assistance (nursing or ADLs) provided in someone's home.	Can be short-term assistance for things like wound care or IV therapy or long-term assistance with medication management, cleaning, shopping, etc.	Care is provided in the client's home.	Patient, client, or member	Daily Living Assistants (DLAs) or CNAs; licensure is not required.
Hospice	Assistance provided for palliative or end-of-life care.	Those who are terminally ill and/or have a life expectancy of six months or less.	Care is available 24 hours, 7 days a week in a resident's home, LTC facility, or hospital unit.	Patient, client, or member	Daily Living Assistants (DLAs) or CNAs; licensure is not required.

2.7 Job-Seeking and Keeping Skills

After completing your coursework, the next step to becoming an employed nursing assistant is to find employment opportunities. You can use local resources, such as newspapers or workforce entities, websites, or social media pages of local health care facilities, or conduct your own search online. After you have completed your clinical experiences, keep in mind the type of facility you prefer to work in and seek out those opportunities for greater job satisfaction. As discussed in "The Survey Process" subsection of this chapter, you can review the survey data of nursing homes to determine their current quality ratings. It is also important to consider staffing ratios when applying for a job. **Staffing ratios** refer to the number of patients assigned each shift to nurses and nursing aides. Working for a facility with good staffing ratios can positively impact your stress level and work-life balance, making this an important characteristic to consider.

You should create a resume to submit with your job application. A **resume** is a factual presentation of yourself that lists your various skills and accomplishments. The goal of your resume is to make an employer want to interview you. Your resume should include your contact information, education, licenses or certifications, and your work experience. You can include skills attained during your nursing assistant training that will pertain directly to the position for which you are applying. You may want to add any honors, awards, or volunteer experiences that would be helpful in highlighting your skills for the position you are seeking. You should also have 2-3 professional references available. References are people who have supervised you in previous jobs or instructors who have observed your skills. Be sure to ask individuals if you can use them as a reference before giving their contact information to your prospective employer.[1]

When you receive a request from a potential employer for an interview, there are many things you can do to prepare yourself. Look at the job description

1. Chippewa Valley Technical College. (n.d.). *Career planning.* https://www.cvtc.edu/experience-cvtc/student-services/career-planning

and be able to specifically state how you can meet the requirements of the job. It is helpful to have someone ask you practice questions. During an interview you are also considering if the facility is a good fit for you. You may want to consider asking for a tour of the facility to observe the environment. Think of questions you want to know about the job such as the following:

- How long is the orientation period?
- What hours will I be expected to work?
- How will I be evaluated?

On the day of the interview, be sure to arrive 10-15 minutes early and have your cell phone silenced. When you meet the person with whom you will interview, make good eye contact and shake hands if appropriate. Speak confidently and truthfully about your abilities. Additionally, you should follow these grooming guidelines:

- Shower, brush your teeth, groom your hair, and trim your nails.
- Wear clean, professional attire without wrinkles, words, or logos.
- If you wear a skirt or dress, make sure it is knee-length or below.
- Do not wear shorts or jeans.
- Wear closed-toed shoes that are in good condition.
- Keep makeup and jewelry to a minimum.
- Use deodorant but no cologne or perfume.

These are all grooming expectations of health care professionals, and it is important to display these qualities the first time you meet your prospective employer.

After you are hired, refer to the areas discussed in "Communication Within the Health Care Team" to meet the needs of your residents and build professional relationships with other staff. Based on the facility's policies, you will have periodic evaluations with your supervisor to discuss your job performance. It is good to reflect on your own performance before the evaluation and be open to any opportunities discussed to improve your care. Be sure to keep your certification and any other training requirements

current so you do not have a lapse in your availability to your residents and peers.

Being a caregiver and helping others can be extremely rewarding, but at times it can also be challenging. Be sure to take care of yourself by getting proper rest, exercise, and nutritional intake. If you don't feel well, you can't take care of others. Refer to information on "Dealing With Stress" in Chapter 1 as to how you can keep yourself mentally healthy to meet the demands of your job.

2.8 Learning Activities

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=189#h5p-5

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=189#h5p-6

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=189#h5p-7

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=189#h5p-8

II Glossary

Citation: A problem or discrepancy found during a survey of a facility by the Department of Health Services.

Elder abuse: An intentional act, or failure to act, that causes or creates a risk of harm to someone 60 or older. The abuse occurs at the hands of a caregiver or a person the older adult trusts.

Elopement: An event when a resident who is incapable of protecting themselves from harm is able to successfully leave the facility unsupervised and unnoticed and possibly enter into harm's way.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Legislation that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.

Mandated reporter: Nursing assistants and other health care professionals are referred to as mandated reporters because they are required by state law to report suspected neglect or abuse of the elderly, vulnerable adults, and children. As a caregiver, you are required to report any signs or symptoms that are suspicious for abuse or neglect to the nurse.

Neglect: Failure to provide care to oneself or to someone for whom you are enlisted to care.

Nursing care plan: A type of documentation created by registered nurses (RNs) that describes the individualized planning and delivery of nursing care for each specific patient using the nursing process.

Nursing process: A critical thinking model based on a systematic approach to patient-centered care that nurses use to perform clinical reasoning and make clinical judgments when providing patient care. The nursing process is based on the Standards of Professional Nursing Practice established by the American Nurses Association (ANA). The mnemonic ADOPIE is an easy way to remember the ANA Standards and the six components of the nursing

process: Assessment, Diagnosis, Outcomes Identification, Planning, Implementation, and Evaluation.[1]

Patient-centered care: A model of health care where an individual's specific health needs and desired health outcomes are the driving force behind all health care decisions. Patients are partners with the health care team members, and health care professionals treat patients not only from a clinical perspective, but also from an emotional, mental, spiritual, social, and financial perspective.

Resume: A factual presentation of yourself that lists your various skills and accomplishments.

Scope of practice: Services that a trained health professional is deemed competent to perform and permitted to undertake according to the terms of their professional license.[2]

Staffing ratios: The number of patients assigned each shift to nurses and nursing aides.

Survey: An evaluative visit by state Department of Health Services (DHS) employees to observe care provided to residents, watch preparation and serving of food, review resident care plans and facility documentation, interview residents and families, and look at every aspect of the facility. The surveyors are ensuring that each aspect of residents' physical, emotional, social, and spiritual needs are met.

Vulnerable populations: Patients who are children, older adults, minorities, socially disadvantaged, underinsured, or those with certain medical conditions. Members of vulnerable populations often have health conditions that are exacerbated by unnecessarily inadequate health care.[3]

1. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0
2. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0
3. Waisel, D. B. (2013). Vulnerable populations. *Current Opinion in Anesthesiology, 26*(2), 186-192. https://doi.org/10.1097/aco.0b013e32835e8c17

PART III

CHAPTER 3: MAINTAIN A SAFE HEALTH CARE ENVIRONMENT

3.1 Introduction to Maintain a Safe Health Care Environment

Learning Objectives

- Maintain a safe, clean, comfortable, therapeutic environment
- Respond appropriately in emergency situations
- Perform airway clearance maneuver
- Apply principles of body mechanics
- Demonstrate safe use and maintenance of equipment and supplies
- Make an occupied and unoccupied bed

Nursing assistants must provide safe, clean, comfortable environments and safely use equipment and supplies. This chapter will review common emergency situations and provide guidelines on how a nursing aide should respond. A typical nursing home environment will be described, and strategies for helping residents transition from living independently to residing in a facility will also be discussed. Proper equipment and body mechanics for lifting residents will also be described to help keep you and those you care for safe.

3.2 Emergency Situations

Nursing assistants must be prepared to respond to emergency situations when providing patient care. Common situations requiring immediate emergency response include heart attacks (myocardial infarctions), strokes (cerebrovascular accidents), seizures, falls, fires, and choking.

Heart Attack or Myocardial Infarction (MI)

Myocardial infarction (MI) is the medical term for what is commonly referred to as a "heart attack." It is caused by a lack of blood flow and oxygen to a region of the heart, resulting in the death of cardiac muscle cells. An MI is typically caused by a blocked coronary artery that occurs when the buildup of plaque creates a clot or when a piece of the plaque breaks off and travels to a smaller vessel, creating a blockage.

When the cardiac muscle cells are starved of oxygen and begin to die during an MI, there is typically a sudden onset of severe pain called **angina** beneath the sternum. This pain often radiates down the left arm or into the jaw. However, some patients (especially female patients) may not experience severe pain but instead experience symptoms that feel like indigestion. Patients may also have associated symptoms like difficulty catching their breath referred to as **shortness of breath (SOB)**, sweating, anxiety, irregular heartbeats, nausea, vomiting, or fainting. Symptoms should be immediately reported to the nurse for emergency assessment and treatment to preserve as much of the heart as possible.[1] See Figure 3.1[2] for an illustration of a male experiencing a myocardial infarction.

1. This work is a derivative of Nursing Pharmacology by Chippewa Valley Technical College and is licensed under CC BY 4.0
2. "A man having a Heart Attack.png" by https://www.myupchar.com/en is licensed under CC BY-SA 4.0.

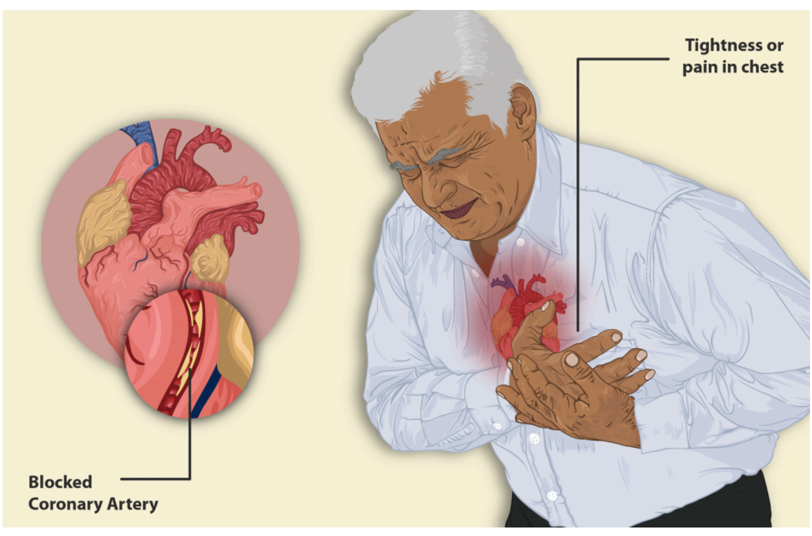


Figure 3.1 Myocardial Infarction

View the following supplementary TED-Ed video[3] with additional information on heart attacks: What Happens During a Heart Attack? – Krishna Sudhir.

Stroke or Cerebrovascular Attack (CVA)

A **cerebrovascular attack (CVA)**, often referred to as a "stroke" or "brain attack," is caused by a lack of blood flow and oxygen to the brain, resulting in the death of brain cells within a few minutes. Similar to the cause of a heart attack, the lack of blood flow is often caused by a blockage in an artery, but in the case of a stroke, the artery is located in the brain. Strokes can also be caused by a blood vessel in the brain rupturing and bleeding, called a hemorrhagic stroke. Risk factors for strokes include smoking, high blood pressure, and **cardiac arrhythmias** (i.e., irregularities in heart rate and/or rhythm).

Lack of blood flow to the brain for more than a few minutes causes irreversible brain damage. The longer a person goes without treatment for a

3. TED-Ed. (2017, February 14). *What happens during a heart attack? - Krishna Sudhir* [Video]. YouTube. All rights reserved. https://youtu.be/3_PYnWVoUzM

stroke, the more damage that occurs to their brain cells. Damaged brain cells can result in paralysis, cognitive impairment, difficulty speaking and understanding words, and mood swings. For this reason, it is important to recognize early signs of a stroke and obtain rapid emergency treatment.

The treatment for a stroke depends on the cause. Eighty percent of strokes occur due to a blockage of an artery in the brain. Strokes caused by a blockage are treated with **thrombolytic medication** (such as tPA) to dissolve the clot. See Figure 3.2[4] for an image of a stroke caused by a blockage. Hemorrhagic strokes occur due to a ruptured vessel in the brain. These types of strokes often require surgery to stop the bleeding. Stroke treatments work best if the symptoms of a stroke are recognized early and emergency treatment occurs within three hours of the onset of symptoms.[5]

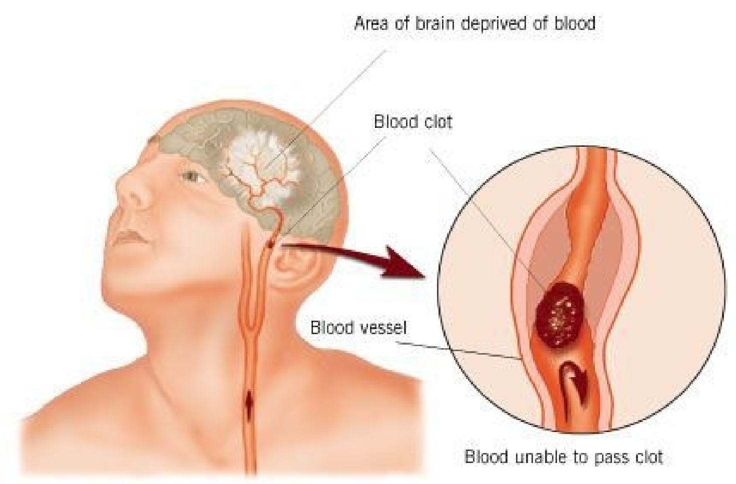


Figure 3.2 Stroke

Strokes typically affect one side of the brain based on where the blood flow was disrupted. Because of the brain's anatomy, the symptoms of a stroke occur on the opposite side of the body as the affected side of the brain. For example, if a stroke occurs in the left side of the brain, the right side of the body will be affected, resulting in signs and symptoms occurring only on the

4. "Stroke Diagram" by ConstructionDealMkting is licensed under CC BY 2.0
5. Centers for Disease Control and Prevention. (2020, August 28). *Stroke*. https://www.cdc.gov/stroke/signs_symptoms.htm

right side of the body. This unilaterality (i.e., one-sidedness) of symptoms is important to recognize and report to the nurse.

The **FAST** acronym is used to remember early signs of a stroke:

- **F:** Facial drooping
- **A:** Arm weakness (unilateral)
- **S:** Slurred speech
- **T:** Time, meaning the quicker the response, the better the outcome

Given the central role and vital importance the brain is to life, it is critical that its blood supply remains uninterrupted. If blood flow is interrupted, even for just a few seconds, a **transient ischemic attack (TIA)**, also called ministroke, may occur. A TIA is a temporary period of symptoms similar to those of a stroke, but they usually last only a few minutes, and they don't cause permanent brain damage. However, TIAs can be a warning sign for a future stroke and should be reported to the nurse.

View a YouTube video[6] from the Centers for Disease Control and Prevention (CDC): Recognizing the Signs and Symptoms of Stroke

Seizure

A **seizure** is a transient occurrence of signs and/or symptoms due to abnormal activity in neurons in the brain. During a seizure, large numbers of brain cells are abnormally activated at the same time, like an electrical storm in the brain. This abnormal neuronal activity often affects a person's consciousness and causes abnormal muscle movements.

6. Centers for Disease Control and Prevention (CDC). (2015, October, 26). Recognize the Signs and Symptoms of Stroke. [Video]. YouTube. All rights reserved. https://youtu.be/cx5G1VdC9UA

Seizures are generally described in two major groups: generalized seizures and focal seizures. The difference between the types of seizures is in how and where they begin in the brain.[7]

Many symptoms can occur during a seizure. They are classified as motor or nonmotor symptoms. Motor symptoms include the following[8]:

- Sustained rhythmic jerking movements (clonic)
- Muscles becoming limp or weak (atonic)
- Body, arms, or legs becoming stiff or tense (tonic)
- Brief twitching (myoclonus)

Nonmotor symptoms are as follows[9]:

- Staring spells (absence seizures)
- Changes in sensation, emotions, thinking, or autonomic functions (nonmotor symptoms)
- Lack of movement (behavioral arrest)

When reporting a seizure to the nurse, include the following three descriptions[10]:

- The time the seizure started
- The person's level of awareness during the seizure
- The movements that occurred during the seizure

If a resident has seizure disorder, it is typically noted in the nursing care plan. If you witness the beginning of a seizure, prepare to take quick action to reduce the chance of injury. For example, if the person is standing, the seizure can cause them to fall. You may not be able to stop the fall but try to guide them to the floor if possible. After they are on the floor, protect their head

7. Epilepsy Foundation. (2020). *Types of seizures.* https://www.epilepsy.com/learn/types-seizures
8. Epilepsy Foundation. (2020). *Types of seizures.* https://www.epilepsy.com/learn/types-seizures
9. Epilepsy Foundation. (2020). *Types of seizures.* https://www.epilepsy.com/learn/types-seizures
10. Epilepsy Foundation. (2020). *Types of seizures.* https://www.epilepsy.com/learn/types-seizures

from directly hitting the floor by placing a pillow or your leg underneath their head. During the seizure, the person may bite their tongue or gag. However, do not place anything in their mouth because this will increase the risk of choking.

Immediately notify the nurse if you observe the start of a seizure and note the time it started. When the seizure has ended, carefully assist the person into bed. Due to the trauma experienced during the seizure, it is typical for the person to sleep for several hours. Some individuals with seizure disorders may also receive antianxiety medication to prevent another seizure from occurring.

View the Epilepsy Foundation's YouTube video[11] of a person experiencing a seizure: Wendy says #ShareMySeizure.

View the Epilepsy Foundation's YouTube video to learn more about seizure first aid[12]: Responding to Seizures: Care and Comfort First Aid.

Falls and Fall Prevention

Falls are common in adults aged 65 years and older. In the United States, about a third of older adults who live at home and about half of people living in nursing homes fall at least once a year. There are many factors that increase the risk of falling in older adults. These risk factors include mobility problems, balance disorders, chronic illnesses, and impaired vision. Many falls cause injury, ranging from mild bruising to broken bones, head injuries, and even death. In fact, falls are a leading cause of death in older adults.

11. Epilepsy Foundation. (2016, November 16). *Wendy says* #ShareMySeizure (30 sec) [Video]. YouTube. All rights reserved. https://youtu.be/KYQXSam1kww
12. Epilepsy Foundation. (2015, November 17). *Responding to seizures: Care and comfort first aid* [Video]. YouTube. All rights reserved. https://youtu.be/PAI9LDq9yas

If you enter a room and discover a resident has fallen, do not move them unless they are in immediate danger of further injury. Notify the nurse as soon as you observe the situation so the resident can be assessed and treated. Typically, a mechanical lift will be used to raise the resident from the floor to prevent injury to themselves and staff.

As a nursing assistant, there are several actions you can take to prevent falls. Keep the environment clean and free of clutter that can cause imbalance while a resident is **ambulating** (i.e., walking). If a spill is noted on the floor, it should be cleaned up immediately. Whenever residents are standing or walking, be sure they are wearing **nonskid footwear** (i.e., shoes or socks with rubberized soles). Use ordered **assistive devices**, such as gait belts and walkers, when moving a resident. If a resident wears glasses or hearing aids, make sure they are functioning, clean, and properly fitted for the resident so the resident can safely assess their surroundings when moving.[13] Additional information on fall risk and preventing falls can be found in Chapter 9.

Fire

In Chapter 2 you learned about agencies that govern health care, such as the Occupational Safety and Health Administration (OSHA). OSHA provides fire regulations and guidelines for every place of employment. This knowledge is essential for keeping residents safe in health care settings due to their limited mobility. Compliance to these regulations when responding to fires is commonly reviewed during the survey process.

The response to a fire can be remembered by the **RACE** and **PASS** acronyms. See Figure 3.3[14] for using the PASS method with a fire extinguisher.

- **R: Rescue** anyone in immediate danger from the fire if it doesn't endanger your life.
- **A: Activate** the alarm by pulling the nearest fire alarm or calling 911.

13. MedlinePlus [Internet]. Bethesda (MD): National Library of Medicine (US). Stroke signs and symptoms; [reviewed 2020, Aug 28; cited 2021, Dec 3]. https://medlineplus.gov/lab-tests/fall-risk-assessment/
14. "RACE-Safety--Arvin61r58.png" by unknown at Freesvg.org is licensed under CC0 1.0

- **C: Contain** the fire by closing all doors and windows.
- **E: Extinguish** the fire if it is small enough using a fire extinguisher and the PASS method. If the fire cannot be extinguished, then **evacuate** patients and oneself from the area. The PASS method includes the following actions:
    - **P: Pull** the pin on the fire extinguisher.
    - **A: Aim** the extinguisher nozzle at the base of the fire.
    - **S: Squeeze** or press the handle.
    - **S: Sweep** from side to side at the base of the flame until the fire appears to be out.

R.A.C.E. for Fire Safety

Procedure will vary among facilities and establishments.
Consult your safety department for further details.

R=RESCUE
Remove anyone in immediate danger from the fire, if it does not endanger your life

A=ALARM
Activate the nearest pull station. Call 911 or your local emergency number and give the location of the fire and fire type.

C=CONTAIN
Confine/contain the fire by closing all doors and windows.

E=EXTINGUISH
If the fire is small enough, extinguish fire with a fire extinguisher using the P.A.S.S. method.
Pull pin
Aim extinguisher
Squeeze lever/handle
Sweep nozzle or hose side to side

Figure 3.3 RACE for Fire Safety

View the UC San Diego Health's YouTube video[15] on using RACE + PASS: RACE + PASS Training.

15. UCSD Visual Media Group. (2019, January 18). *RACE + PASS training* [Video]. YouTube. All rights reserved. https://youtu.be/pVHFdEivyNE

Choking and Airway Clearance

Choking is a common cause of unintentional injury and death. Over half of the people who die from choking are over the age of 70.[16] Food is often responsible for choking incidents in the elderly, especially those who have difficulty swallowing or have dentures. Many people who have dementia or who have had a previous stroke have difficulty swallowing. If you see any signs of choking, immediately notify the nurse and take action to clear the person's airway.

If you are in a setting without a nurse present, it is important for you to know what to do and how to rescue someone who is choking. If a person is continuing to cough forcefully, encourage continued coughing to clear the object. However, a person who can't cough, speak, or breathe needs immediate help. Ask the person if they are choking and let them know you will use abdominal thrusts, known as the **Heimlich maneuver**, to help them clear their airway and breathe. (Keep in mind the Heimlich maneuver is not recommended for children younger than 1.) See Figure 3.4[17] for an image of the Heimlich maneuver.

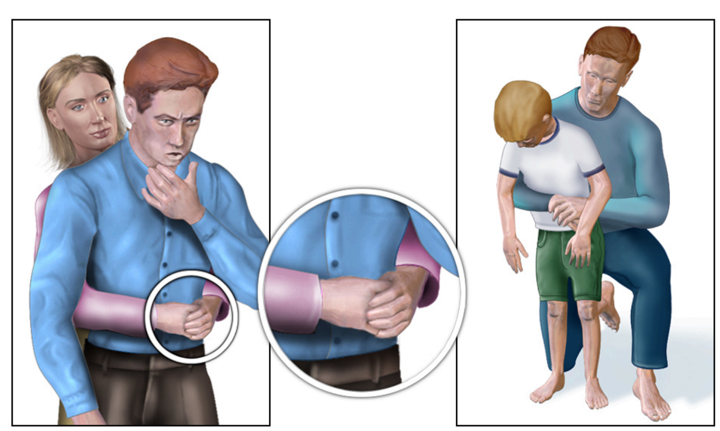


Figure 3.4 Heimlich Maneuver

16. National Safety Council. (n.d.). *Choking prevention and rescue tips.* https://www.nsc.org/home-safety/safety-topics/choking-suffocation
17. "Heimlich_Adult_%26_Child.png" by BruceBlaus is licensed under CC BY-SA 4.0

To perform the Heimlich maneuver, perform the following steps[18]:

- Stand behind the victim with one leg forward between the victim's legs. If the person is sitting in a wheelchair or not able to stand, lean them forward in the chair and stand behind them.
- For a child, move down to their level and keep your head to one side.
- Reach around the abdomen and locate the navel.
- Place the thumb side of your fist against the abdomen just above the navel.
- Grasp your fist with your other hand and thrust inward and upward into the victim's abdomen with quick jerks.
- For a responsive pregnant victim, any victim you cannot get your arms around, or for anyone in whom abdominal thrusts are not effective, give chest thrusts while standing behind them. Avoid squeezing the ribs with your arms.
- Continue thrusts until the victim expels the object or becomes unresponsive.
- If the person becomes unconscious, perform standard cardiopulmonary resuscitation (CPR) with chest compressions and rescue breaths.
- After choking stops, seek medical attention for the client.

View the "Skills Checklist: Choking Maneuver" with an associated video of performing the Heimlich maneuver.

18. National Safety Council. (n.d.). *Choking prevention and rescue tips*. https://www.nsc.org/home-safety/safety-topics/choking-suffocation

3.3 Resident Environment

When an individual moves into a nursing home, it can be a complicated, stressful, and sometimes confusing time for them and their loved ones. Because nurse aides spend more time with residents than any other staff member, your actions are critical to help ease their worries associated with a change in their environment.

Reflective Activity

Reflect about a time when you moved, changed schools, started a new job, or went to a new place on your own. What things made you feel more comfortable during those transitions? Applying how you felt during those experiences can help you empathize with and provide peace of mind for anyone experiencing a transition.

In addition to experiencing a new environment, newly admitted residents have also typically had a recent major change in cognitive or physical functioning. They are adjusting to not only a new environment but also to how they feel, think, and move. Actions that were previously taken for granted, such as walking, eating, and performing self-care, now require assistance from others. Review the activity in the Chapter 1 subsection "Managing Clients' and Family Members' Stress" to increase your awareness of factors that may affect a resident's outlook and the ways you can improve their quality of life.

As a nurse aide, you can be a major factor in promoting better outcomes for residents by making observations related to their nutritional intake, physical activity, and psychosocial well-being and communicating these observations to the nurse. The Fulmer SPICES tool is a good framework for promoting health in the older adult population. **SPICES** is an acronym that stands for observing the following aspects that can affect well-being for older adults:

Sleep, **P**roblems eating, **I**ncontinence, **C**onfusion, **E**vidence of falls, and **S**kin Breakdown[1]:

- **Sleep:** Older adults need 7-9 hours of sleep per day. To promote good sleep, control environmental factors such as noise, lighting, and temperature. Report sleep disturbances such as excessive snoring or gasping for air or if the resident states they don't feel rested on awakening.[2]
- **Problems Eating:** Report issues with chewing and swallowing during meals, as well as residents' food preferences. Insufficient nutritional intake can lead to skin breakdown issues, infection, and an overall decline in function. More information about eating problems can be found in Chapter 5.
- **Incontinence: Incontinence** is a lack of voluntary control over urination or defecation. Offer toileting to your residents at least every two hours and on their request. Check incontinence products at least every two hours, especially for those residents with communication problems. More information about incontinence can be found in Chapter 5.
- **Confusion:** Report any new onset of confusion because it can be a sign of infection. An example of a resident with new confusion would be not knowing the day of the week or where they are when normally they are aware and oriented.
- **Evidence of Falls:** Report any new weakness or difficulty in transferring from bed to wheelchair or a change in the ability to walk. Read more about fall prevention in the "Emergency Situations" section of this chapter and in Chapter 9.
- **Skin Breakdown:** Damage to the skin is called **skin breakdown**. Common preventable causes of skin breakdown are immobility and incontinence. For residents who are unable to independently move, reposition them at least every two hours. For residents with incontinence, provide proper

1. Aronow, H. U., Borenstein, J., Haus, F., Braunstein, G. D., & Bolton, L. B. (2014). Validating SPICES as a screening tool for frailty risks among hospitalized older adults. *Nursing Research and Practice, 2014*, 846759. https://doi.org/10.1155/2014/846759
2. Centers for Disease Control and Prevention. (2017, March 2). *How much sleep do I need?* https://www.cdc.gov/sleep/about_sleep/how_much_sleep.html

hygiene to keep their skin clean and dry. More information about skin breakdown can be found in Chapter 5.

Transitioning to a New Environment

Transitioning to a nursing home environment involves an abrupt change to an individual's living environment in terms of privacy, size, and personal belongings. See an image of a typical shared room in a nursing home in Figure 3.5.[3] In addition to this change in environment, residents often cannot follow their typical schedule they had at home, although accommodations should be made to meet their preferences as much as possible.

Figure 3.5 Typical Resident Environment in a Nursing Home

Nurse aids help residents transition to a new environment. When a new admission is expected, a staff member should be at the entry area to greet the individual and their loved ones. The room should be prepared before arrival, which includes sanitization procedures and making the bed. Read more about how to make a hospital bed in the "Skills Checklist" section of this chapter.

Actions to help residents transition to their new environment include the following:

3. "residentroom.jpg" by unknown for Stratford Manor. Image used under Fair Use. Access for free at https://stratfordrehab.com/

- Introduce the resident to the staff and identify who is responsible for which resident care needs, such as CNAs, dietary aides, activities personnel, nurses, etc.
- Provide a tour of the facility.
- Show the resident where they can find the daily schedule of events and activities.
- Assist the resident in organizing their belongings and arranging their room to fit their needs and preferences.
- Introduce their roommate if they are sharing a room.
- If possible, arrange to have a resident mentor. A **resident mentor** is another resident who can answer questions and encourage interaction.

Every facility has their own admission procedures, but a common requirement is the completion of a written inventory of the resident's belongings. This inventory is typically done by the nurse aide depending upon the care setting. See an example of a Resident Personal Belongings Inventory used in an adult family home in Figure 3.6.[4]

4. "Adult Family Home Resident Personal Belongings Inventory (Residential Care Services)" by Washington State Department of Social and Health Services is in the Public Domain. Access for free at https://www.dshs.wa.gov/office-of-the-secretary/forms

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)

Adult Family Home Resident Personal Belongings Inventory

WAC 388-76-10320

Instructions: Provider or Resident Manager completes upon admission. The Provider/Resident Manager and the resident or the resident's guardian or agent sign. File in the resident's record. Records and information concerning each person in care shall be maintained in such a manner as to preserve confidentiality.

RESIDENT'S NAME	NAME OF RESIDENT'S GUARDIAN	DATE OF ADMISSION
CONTACT LENSES	DENTURES	
EYE GLASSES	HEARING AID	
JEWELRY	WATCH	
MONEY/CHECKBOOK/CREDIT CARDS	OTHER	

CLOTHING LIST

NUMBER	ITEM	DESCRIPTION
	Bathrobe	
	Belt	
	Blouse	
	Brassiere	
	Coat	
	Dress	
	Girdle	
	Gloves	
	Handkerchief	
	Hat	
	House coat	
	Necktie	
	Nightgown	
	Pajamas	
	Pants	
	Shirts	
	Shoes	
	Skirts	
	Slippers	
	Slips	
	Socks	
	Stockings	
	Suit	
	Suspenders	
	Sweater	
	Undershirt	
	Underpants	
	Underwear - long	
	Vests	
	Other:	

MISCELLANEOUS

NUMBER	ITEM	DESCRIPTION
	Brush	
	Cane or crutches	
	Clock	
	Luggage	
	Radio	
	Television (model and serial number)	
	Walker	
	Wheelchair (model and serial number)	
	Other:	

Statement: I have read and agree that this is an accurate list of my belongings.

PROVIDER'S/RESIDENT MANAGER'S SIGNATURE	DATE	RESIDENT'S OR GUARDIAN'S SIGNATURE	DATE

DSHS 02-516 (REV. 07/2017)

Figure 3.6 Sample Resident Belonging Inventory

3.4 Body Mechanics and Safe Equipment Use

In addition to promoting safety for patients and their families, it is important for health care workers to be aware of safety risks in the environment and to take measures to protect themselves. Common safety risks to health care workers include sharps injuries, exposure to blood-borne pathogens, lack of personal protective equipment, and lifting injuries. A **sharps injury** is a penetrating wound from a needle, scalpel, or other sharp object that may result in exposure to blood-borne pathogens. **Blood-borne pathogens** are pathogenic microorganisms present in blood and body fluids that can cause disease such as hepatitis B (HBV) and human immunodeficiency virus (HIV). **Personal protective equipment (PPE)** is used to prevent transmission of blood-borne pathogens and infection and includes gloves, masks, goggles, gowns, and other types of protective equipment. This section will focus on lifting injuries related to moving clients, and the other safety risks will be discussed in Chapter 4.

The health and well-being of nurse aides is directly related to the quality of care residents receive. When a health care worker is injured, they may be unable to provide care to the extent required by residents. With this in mind, it is vital for nursing assistants to know how to prevent injury in the workplace. An article published in the 2018 *International Journal of Environmental Research and Public Health* noted that 88% of nurse aides reported at least one of their body parts having a **work-related musculoskeletal symptoms (WRMS)**.[1] The lower back was the most commonly affected WRMS area, followed by the arms and shoulders. According to this study, nursing assistants ranked first for occupational-related back sprains and strains, above construction workers, garbage collectors, and other health care workers. WRMS reported by nurse aides account for over 50% of all musculoskeletal injuries reported in the United States. These injuries are attributed to manual

1. Cheung, K., Szeto, G., Lai, G., & Ching, S. (2018). Prevalence of and factors associated with work-related musculoskeletal symptoms in nursing assistants working in nursing homes. *International Journal of Environmental Research and Public Health, 15*(2), 265. https://doi.org/10.3390/ijerph15020265

handling of clients, lifting heavy physical loads, assuming frequent awkward positions, and performing repetitive movements.[2]

Using gait belts and mechanical lifts for transferring residents from one location to another, such as from the bed to a wheelchair or a wheelchair to the toilet, has greatly reduced the risk of lifting injuries to both residents and aides. These transferring techniques will be discussed in Chapter 8.

Lifting injuries can also occur when repositioning residents while they are in bed. Repositioning is frequently performed for residents to provide hygiene, alleviate pain, or prevent skin breakdown. The ABC mnemonic for using proper body mechanics when transferring or repositioning residents stands for **A**lignment, **B**ase of support, and **C**enter of gravity[3]:

- **Alignment:** Correct body alignment is also referred to as good posture. When standing up straight, an imaginary line should be able to be drawn straight down through the center of the body so that both sides of the body are mirror images of each other. Body parts should be lined up naturally, with arms at one's side, palms directed forward, and feet pointed forward and slightly apart. Follow these guidelines to use proper alignment to prevent lifting injuries:
    - Maintain correct body alignment when lifting or carrying an object.
    - Keep the object close to your body, unless close proximity could transmit pathogens.
    - Point your feet and body in the direction you are moving.
    - Do not twist at the waist.
- **Base of support:** Creating a good base of support improves your balance, whereas imbalance creates awkward positioning that can lead to injury. To create a strong base of support, place your feet about shoulder width apart or just slightly wider than your hips.

2. Cheung, K., Szeto, G., Lai, G., & Ching, S. (2018). Prevalence of and factors associated with work-related musculoskeletal symptoms in nursing assistants working in nursing homes. *International Journal of Environmental Research and Public Health, 15*(2), 265. https://doi.org/10.3390/ijerph15020265
3. North Carolina Department of Health and Human Services. (2019). *State-approved curriculum: Nurse aide I Training program*. https://info.ncdhhs.gov/dhsr/hcpr/curriculum/pdf/moduleI.pdf

- **Center of gravity:** A person's center of gravity is where most of one's weight is concentrated. When standing, the pelvis is the center of gravity. Maintaining a low center of gravity provides a stable base of support and improves balance.

For example, when lifting objects or people, keep your center of gravity low with a good base of support by bending at the knees with the feet shoulder width apart. Keep in mind that your center of gravity also includes the resident or the object, so keep them as close to your body as possible. To maintain good alignment, face the person or object you are moving and use both sides of your body equally. Figure 3.7[4] illustrates safer body mechanics in Option "C" by maintaining good alignment, establishing a base of support, and keeping the load close and near to one's center of gravity while bending the knees.

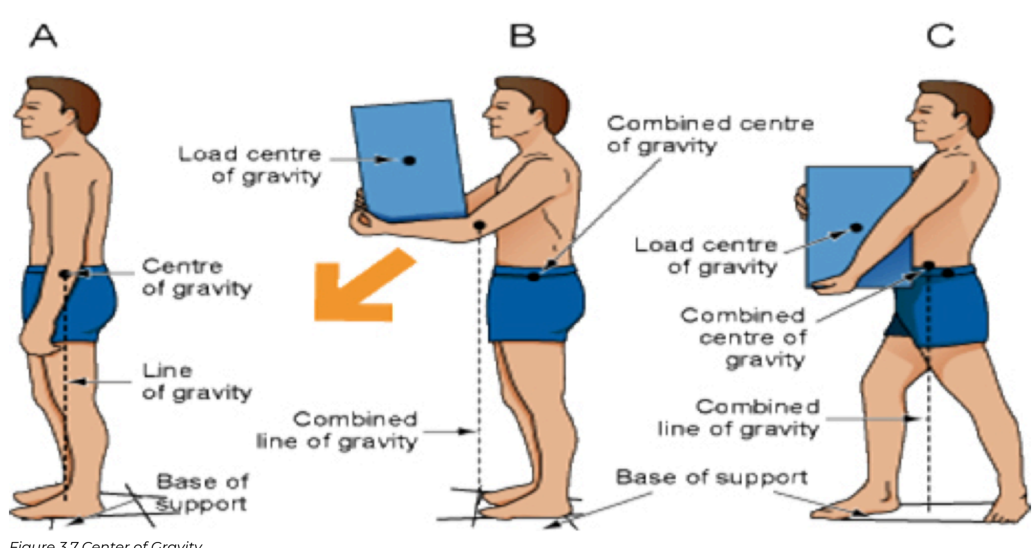


Figure 3.7 Center of Gravity

Facilities have specialized equipment used to assist in lifting and transferring clients that significantly reduces the risk of lifting injuries. Manufacturers provide specific instructions for the safe use and maintenance of their equipment. Be certain that you receive extensive training on safely using this

4. "Centre_of_Gravity.png" by Glynda Rees Doyle and Jodie Anita McCutcheon is licensed under CC BY 4.0. Access for free at https://opentextbc.ca/clinicalskills/chapter/3-2-body-mechanics/

equipment during your orientation to the facility. Orientation to lifting equipment should include becoming familiar with all parts of the device, the requirements for the mobility status of residents who will use that device, and potential risks to residents and caregivers while using the device. See Figure 3.8[5] for an image of lifting equipment.

Figure 3.8 Lifting Equipment

> For additional information on OSHA regulations for using lifting equipment and preventing lifting injuries, refer to this document: Guidelines for Nursing Homes PDF.

5. "User-Integra-lifter1.jpg" by Integracp is licensed under CC BY-SA 3.0

3.5 Skills Checklist: Making an Unoccupied Bed Checklist

Bed making is a necessary skill for nursing assistants to keep the environment clean, prevent skin breakdown and the spread of infection, and respect the resident's dignity by providing an orderly environment. Linens should be changed at least weekly or whenever they become soiled.

Follow these infection control guidelines when making beds:

- Never allow linens to touch your uniform.
- Do not transfer linens from one room to another.
- Do not place soiled linens on the floor.
- If linens touch the floor, they should be placed in the soiled laundry for cleaning and not used.
- Do not shake linens because it can spread airborne pathogens.
- Store clean linens in a closed closet or a covered cart.

Making an Unoccupied Bed Checklist

1. Gather Supplies: Linens

2. Routine Pre-Procedure Steps:

    - Knock on the client's door.
    - Perform hand hygiene.
    - Introduce yourself and identify the resident.
    - Maintain respectful, courteous, and professional communication at all times.
    - Provide for privacy.
    - Explain the procedure to the client.

3. Procedure Steps:

    - Place a clean barrier on a flat surface. Flip the linens over and place them on the barrier so the fitted sheet is on top.
    - Don gloves.

- Look for any personal belongings that may have been left in the bed and return them to their proper place.
- Untuck the corners and roll all linens together to the middle of the bed.
- Place soiled linens in a linen bag or other appropriate container according to facility policy.
- Remove gloves.
- Perform hand hygiene.
- If the bed is soiled, sanitize it or notify environmental services to sanitize it.
- After the bed has dried from sanitization, place the fitted sheet on the bed. Seams should be against the mattress and away from the resident. Smooth the sheet to prevent wrinkles that can cause injury to fragile skin. (Note: If a flat sheet is used as the bottom sheet, refer to sub-bullets below for details on making mitered corners.)
- Place the lift sheet where it is estimated the resident's shoulders to hips will be when they are in bed.
- Place a soaker pad or other waterproof barrier on top of the lift sheet.
- Place the flat sheet on top and smooth it out. Make mitered corners at the foot of the bed by doing the following:
    - Tuck the entire end of the sheet under the foot of the bed.
    - While facing the foot of the bed, create a 45-degree angle from the corner of the bed with the sheet.
    - Place the angled edge of the sheet on top of the bed and tuck in anything hanging below the bed frame.
    - Lower the angled sheet back over the edge of the bed.
- Place a bedspread or blanket on top of the sheet per the resident's preference. Make a mitered corner in the bedspread or blanket by performing the steps above.
- Lay a pillow on the bed and slide the pillowcase over the pillow.
- Put the pillow at the head of the bed with the open end of the pillowcase faced away from the door. Repeat for multiple pillows.

4. Post-Procedure Steps:

- Perform hand hygiene.
- Check on resident comfort and ask if anything else is needed.
- Ensure the bed is low and locked. Check the brakes.
- Place the call light or signaling device within reach of the resident.
- Open the door and privacy curtain.
- Perform hand hygiene.
- Report abnormal findings to the nurse.

View a YouTube video[1] of a nursing instructor demonstrating making an unoccupied bed:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nurseassist/?p=230#oembed-1

1. Chippewa Valley Technical College. (2022, December 3). Making an Unoccupied Bed. [Video]. YouTube. Video licensed under CC BY 4.0. https://youtu.be/K0c9fSd46JA

3.6 Skills Checklist: Making an Occupied Bed

Bed making is a necessary skill for nursing assistants to keep the environment clean, prevent skin breakdown and the spread of infection, and respect the resident's dignity by providing an orderly environment. Linens should be changed at least weekly or whenever they become soiled.

Follow these infection control guidelines when making beds:

- Never allow linens to touch your uniform.
- Do not transfer linens from one room to another.
- Do not place soiled linens on the floor.
- If clean linens touch the floor, they should be placed in the soiled laundry for cleaning and not used.
- Do not shake linens because it can spread airborne pathogens.
- Store clean linens in a closed closet or a covered cart.

Making an Occupied Bed Checklist

1. Gather Supplies: Linens
2. Routine Pre-Procedure Steps:
    - Knock on the client's door.
    - Perform hand hygiene.
    - Introduce yourself and identify the resident.
    - Maintain respectful, courteous, and professional communication at all times.
    - Provide for privacy.
    - Explain the procedure to the client.

3. Procedure Steps:

    - Place a clean barrier on a flat surface, flip linens over, and place them on the barrier so the fitted sheet is on top.
    - Don gloves.

- Look for any personal belongings that may have been left in the bed and return them to their proper place.
- Put the side rail up.
- Move to the opposite side of the bed.
- Using the lift sheet, roll the resident towards the side rail.
- Begin rolling soiled linens to the middle of the bed and under the resident.
- Remove gloves.
- Perform hand hygiene.
- Place a fitted sheet on the half of the bed you are working on.
- Place the lift sheet and soaker pad in the same manner, fan folding them under the resident.
- Raise the side rail.
- Move to the opposite side of the bed.
- Put on gloves.
- Lower side rail on working side of the bed.
- Roll the resident to the opposite side.
- Remove the soiled linens and place them in a linen bag.
- Remove gloves.
- Perform hand hygiene.
- Pull through the fitted sheet, lift sheet, and soaker pad, ensuring there are no wrinkles.
- Assist the resident to a supine position.
- Keeping the resident covered, place a new flat sheet on top of them.
- Make mitered corners at the foot of the bed by doing the following:
    - Tuck the entire end of the sheet under the foot of the bed.
    - Facing the foot of the bed, create a 45-degree angle from the corner of the bed with the sheet.
    - Place the angled sheet on top of the bed and tuck in anything hanging below the bed frame.
    - Lower the angled sheet over the edge of the bed.
- Put a clean pillowcase on a new pillow and exchange it for the soiled pillow. Put the pillow at the head of the bed with the open end of the

pillowcase faced away from the door. Repeat for multiple pillows.
  - Repeat steps for any blankets or bedspreads.
  - Make a toe pleat (i.e., a pleat in the sheet which allows an individual to move feet) to prevent pressure.

4. Post-Procedure Steps:

  - Perform hand hygiene.
  - Check on resident comfort and ask if anything else is needed.
  - Ensure the bed is low and locked. Check the brakes.
  - Place the call light or signaling device within reach of the resident.
  - Open the door and privacy curtain.
  - Perform hand hygiene.
  - Report abnormal findings to the nurse.

View a YouTube video[1] of a nursing instructor demonstrating making an occupied bed:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nurseassist/?p=1920#oembed-1

1. Chippewa Valley Technical College. (2022, December 3). Making an Occupied Bed. [Video]. YouTube. Video licensed under CC BY 4.0. https://youtu.be/AN9pvC499P4

3.7 Learning Activities

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=232#h5p-9

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=232#h5p-10

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=232#h5p-70

III Glossary

Ambulating: Walking.

Angina: Sudden chest pain beneath the sternum (breastbone) associated with a heart attack (myocardial infarction), often radiating down the left arm in male patients.

Assistive devices: Devices such as gait belts and walkers that are used when moving a patient.

Blood-borne pathogens: Pathogenic microorganisms present in blood and body fluids that can cause disease such as hepatitis B (HBV) and human immunodeficiency virus (HIV).

Cardiac arrhythmias: Irregularities in a person's heart rate and/or rhythm.

Cerebrovascular attack (CVA): The medical term for what is commonly referred to as a "stroke," caused by a lack of blood flow and oxygen to the brain.

FAST: An acronym used to remember the early signs of a stroke: Facial drooping, Arm weakness, Slurred speech, and Time (meaning the quicker the response, the better the outcome).

Heimlich maneuver: A procedure used for someone who is choking that uses abdominal thrusts to clear the airway so they can breathe.

Incontinence: A lack of voluntary control over urination or defecation.

Myocardial infarction (MI): The medical term for what is commonly referred to as a "heart attack," caused by a lack of blood flow and oxygen to the heart.

Nonskid footwear: Shoes or socks with rubberized soles used to prevent falls.

PASS: An acronym for using a fire extinguisher that stands for the following:

- P: Pull the pin on the fire extinguisher.

- A: Aim the extinguisher nozzle at the base of the fire.
- S: Squeeze or press the handle.
- S: Sweep from side to side at the base of the flame until the fire appears to be out.

Personal protective equipment (PPE): Equipment used to prevent transmission of blood-borne pathogens and infection, including gloves, masks, goggles, gowns, and other types of protective equipment.

RACE: An acronym for responding to a fire that stands for the following:

- R: Rescue anyone in immediate danger from the fire if it doesn't endanger your life.
- A: Activate the alarm by pulling the nearest fire alarm or calling 911.
- C: Contain the fire by closing all doors and windows.
- E: Extinguish the fire if it is small enough using a fire extinguisher and the PASS method. Evacuate patients and oneself if the fire cannot be extinguished.

Resident mentor: A resident who can answer questions and encourage interaction for a new resident recently admitted to a long-term care facility.

Seizure: A transient occurrence of signs and/or symptoms due to abnormal neuronal activity in the brain.

Sharps injury: A penetrating wound from a needle, scalpel, or other sharp object that may result in exposure to blood-borne pathogens.

Shortness of breath (SOB): Difficulty breathing or a feeling of not being able to catch one's breath.

Skin breakdown: Damage to the skin due to common preventable causes like immobility and incontinence.

SPICES: An acronym that stands for observing the following aspects of well-being for older adults: Sleep, Problems eating, Incontinence, Confusion, Evidence of falls, and Skin breakdown.

Thrombolytic medication: Medication (such as tPA) used to dissolve clots in arteries.

Transient ischemic attack (TIA): A medical term for what is commonly referred to as a ministroke. A TIA is a temporary period of symptoms similar to those of a stroke that usually last only a few minutes and don't cause permanent brain damage.

Work-related musculoskeletal symptoms (WRMS): Symptoms from musculoskeletal injuries experienced at work, such as lower back pain, that are attributed to manual handling of clients, heavy physical loads, frequent awkward positions, and repetitive movements.

PART IV

CHAPTER 4: ADHERE TO PRINCIPLES OF INFECTION CONTROL

4.1 Introduction to Adhere to Principles of Infection Control

Learning Objectives

- Discuss principles of medical asepsis for client and personal safety
- Describe methods to prevent blood-borne pathogen transmission
- Apply principles of standard and transmission-based precautions and infection prevention

Infection control, also called infection prevention, prevents or stops the spread of infections in health care settings.[1] Facilities hire licensed health professionals who are in charge of infection prevention, but everyone is responsible for reducing the spread of infection. This chapter will discuss the manner in which infections spread, common signs and symptoms of infection, and infection control basics, including methods to protect you and those you care for from infection.

1. Centers for Disease Control and Prevention. (2020, April 29). *Infection control*. https://www.cdc.gov/infectioncontrol/index.html

4.2 Chain of Infection

The **chain of infection**, also referred to as the chain of transmission, describes how an infection spreads based on these six links of transmission:

- Infectious Agent
- Reservoirs
- Portal of Exit
- Modes of Transmission
- Portal of Entry
- Susceptible Host

See Figure 4.1[1] for an illustration of the chain of infection. If any "link" in the chain of infection is removed or neutralized, transmission of infection will not occur. Health care workers must understand how an infectious agent spreads via the chain of transmission so they can break the chain and prevent the transmission of infectious disease. Routine hygienic practices, standard precautions, and transmission-based precautions are used to break the chain of transmission.

1. "Chain-of-Transmission" by unknown author is licensed under CC BY-NC 4.0. Access for free at https://ecampusontario.pressbooks.pub/introductiontoipcp/chapter/40/

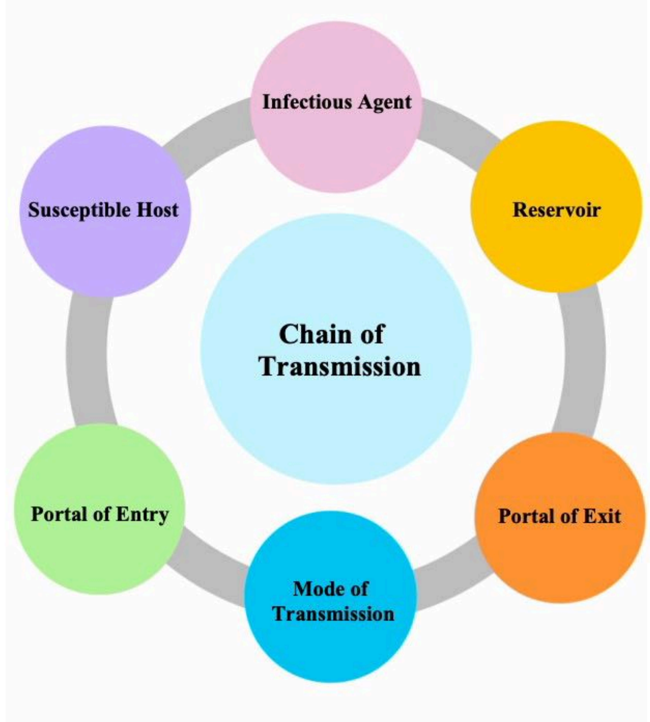


Figure 4.1 Chain of Infection

The links in the chain of infection include Infectious Agent, Reservoir, Portal of Exit, Mode of Transmission, Portal of Entry, and Susceptible Host[2]:

- **Infectious Agent:** Microorganisms, such as bacteria, viruses, fungi, or parasites, that can cause infectious disease.
- **Reservoir:** The host in which infectious agents live, grow, and multiply. Humans, animals, and the environment can be reservoirs. Examples of reservoirs are a person with a common cold, a dog with rabies, or standing water with bacteria. Sometimes a person may carry an infectious agent but is not symptomatic or ill. This is referred to as being **colonized**, and the person is referred to as a **carrier**. For example, many health care workers carry *methicillin-resistant Staphylococcus aureus* (MRSA) bacteria in their noses but are not symptomatic.
- **Portal of Exit:** The route by which an infectious agent escapes or leaves the reservoir. In humans, the portal of exit is typically a mucous membrane or other opening in the skin. For example, pathogens that

2. Department of Health. (n.d.). *Chain of infection in infection prevention and control (IPAC).* The Government of Nunavut. https://www.gov.nu.ca/health/information/infection-prevention-and-control

cause respiratory diseases usually escape through a person's nose or mouth.

- **Mode of Transmission:** The way in which an infectious agent travels to other people and places because they cannot travel on their own. Modes of transmission include contact, droplet, or airborne transmission. For example, touching sheets with drainage from one person's infected wound and then touching another person without washing one's hands is an example of contact transmission of an infectious agent. Examples of droplet or airborne transmission are coughing and sneezing, depending on the size of the microorganism.
- **Portal of Entry:** The route by which an infectious agent enters a new host (i.e., the reverse of the portal of exit). For example, mucous membranes, skin breakdown, and artificial openings in the skin created for the insertion of medical equipment (such as intravenous lines) are at high risk for infection because they provide an open path for microorganisms to enter the body. Tubes inserted into mucous membranes, such as a urinary catheter, also facilitate the entrance of microorganisms into the body. A person's immune system fights against infectious organisms that have entered the body through the use of nonspecific and specific defenses. Read more about defenses against microorganisms in the "Defenses Against Transmission of Infection" section of this chapter.
- **Susceptible Host:** A person at elevated risk for developing an infection when exposed to an infectious agent due to changes in their immune system defenses. For example, infants (up to 2 years old) and older adults (aged 65 or older) are at higher risk for developing infections due to underdeveloped or weakened immune systems. Additionally, anyone with chronic medical conditions (such as diabetes) are also at higher risk of developing an infection. In health care settings, almost every patient is considered a "susceptible host" because of preexisting illnesses, medical treatments, medical devices, or medications that increase their vulnerability to developing an infection when exposed to infectious agents in the health care environment. As caregivers, it is the NA's responsibility to protect susceptible patients by breaking the chain of infection.

After a susceptible host becomes infected, they become a reservoir that can then transmit the infectious agent to another person. If an individual's immune system successfully fights off the infectious agent, they may not develop an infection, but instead the person may become an asymptomatic "carrier" who can spread the infectious agent to another susceptible host. For example, individuals exposed to COVID-19 may not develop an active respiratory infection but can spread the virus to other susceptible hosts via sneezing.

Learn more about the chain of infection by clicking on the following activities.

An interactive H5P element has been excluded from this version of the text. You can view it online here: https://wtcs.pressbooks.pub/nurseassist/?p=351#h5p-29

This H5P activity is a derivative of original activities by Michelle Hugues and licensed under CC BY-NC 4.0 unless otherwise noted.

An interactive H5P element has been excluded from this version of the text. You can view it online here: https://wtcs.pressbooks.pub/nurseassist/?p=351#h5p-30

This H5P activity is a derivative of original activities by Michelle Hugues and licensed under CC BY-NC 4.0 unless otherwise noted.

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=351#h5p-31

This H5P activity is a derivative of original activities by Michelle Hugues and licensed under CC BY-NC 4.0 unless otherwise noted.

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=351#h5p-32

This H5P activity is a derivative of original activities by Michelle Hugues and licensed under CC BY-NC 4.0 unless otherwise noted.

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=351#h5p-33

This H5P activity is a derivative of original activities by Michelle Hugues and licensed under CC BY-NC 4.0 unless otherwise noted.

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=351#h5p-36

This H5P activity is a derivative of original activities by Michelle Hugues and licensed under CC BY-NC 4.0 unless otherwise noted.

PUTTING IT ALL TOGETHER

Note: To enlarge the print, you can expand the activity by clicking the arrows in the right upper corner of the text box. Please drag and drop the descriptors and actions into the appropriate boxes to demonstrate the various steps in the chain of infection.

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=351#h5p-16

This H5P activity is a derivative of original activities by Michelle Hugues and licensed under CC BY-NC 4.0 unless otherwise noted.

Healthcare-Acquired Infections

An infection that develops in an individual after being admitted to a health care facility or undergoing a medical procedure is a **healthcare-associated infection (HAI)**, formerly referred to as a nosocomial infection. About 1 in 31 hospital patients develops at least one healthcare-associated infection every

day. HAIs increase the cost of care and delay recovery. They are associated with permanent disability, loss of wages, and even death. An example of an HAI is a skin infection that develops in a patient's incision after they had surgery due to improper hand hygiene of health care workers.[3,4] It is important to understand the dangers of Healthcare-Acquired Infections and actions that can be taken to prevent them.

Read more details about healthcare-acquired infections in the "Infection" chapter of Open RN *Nursing Fundamentals*.

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=351#h5p-42

Healthcare-Associated Infections by Michelle Hughes is licensed under CC BY 4.0.

3. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0
4. Office of Infectious Disease and HIV/AIDS Policy. (n.d.). *Health care-associated infections.* U.S. Department of Health & Human Services. https://www.hhs.gov/oidp/topics/health-care-associated-infections/index.html

4.3 Defenses Against Transmission of Infection

The body tries to protect itself from infectious agents by using specific and nonspecific defenses. **Specific defenses** are immune system processes that include white blood cells attacking particular pathogens. **Nonspecific defenses** are generic barriers that prevent pathogens from entering the body, including physical, mechanical, or chemical barriers.

Physical Defenses

Physical defenses are the body's most basic form of defenses against infection. Physical defenses include barriers such as skin and mucous membranes, as well as mechanical defenses, that physically remove microbes from areas of the body.[1]

SKIN

One of the body's most important physical barriers is the skin barrier that is composed of three layers of closely packed cells. See Figure 4.2[2] for an illustration of layers of the skin. The topmost layer of skin, called the epidermis, consists of cells that are packed with keratin. Keratin makes the skin's surface mechanically tough and resists degradation by bacteria. When the skin barrier becomes broken, such as becoming cracked from dryness, microorganisms can enter and cause infection.[3]

1. This work is a derivative of Microbiology by OpenStax and is licensed under CC BY 4.0. Access for free at https://openstax.org/books/microbiology/pages/1-introduction
2. "OSC_Microbio_17_02_Skin.jpg" by OpenStax is licensed under CC BY 4.0. Access for free at https://openstax.org/books/microbiology/pages/17-1-physical-defenses
3. This work is a derivative of Microbiology by OpenStax and is licensed under CC BY 4.0. Access for free at https://openstax.org/books/microbiology/pages/1-introduction

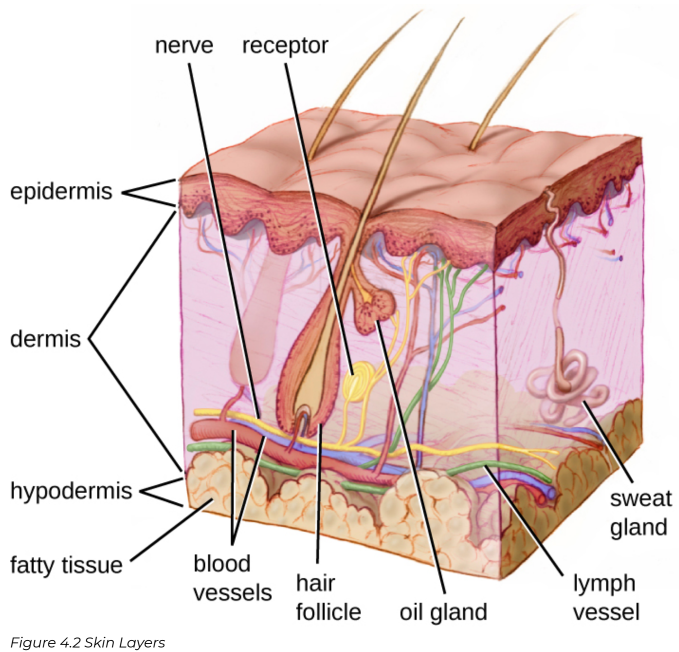


Figure 4.2 Skin Layers

MUCOUS MEMBRANES

Mucous membranes lining the nose, mouth, lungs, and urinary and digestive tracts provide another nonspecific barrier against pathogens. Mucous is a moist, sticky substance that covers and protects the layers beneath it and also traps debris, including microbes. Mucus secretions also contain antimicrobial agents.[4]

In many regions of the body, mechanical actions flush mucus (along with trapped microbes) out of the body or away from potential sites of infection. For example, in the respiratory system, inhalation can bring microbes, dust, mold spores, and other small airborne debris into the body. This debris becomes trapped in the mucus lining the respiratory tract. The cells lining the upper parts of the respiratory tract have hair-like appendages known as cilia. Movement of the cilia propels debris-laden mucus out and away from the lungs. The expelled mucus is then swallowed (and destroyed in the stomach) or coughed out. However, smoking limits the efficiency of this system, making smokers more susceptible to developing respiratory infections. Additionally, as people age, their chest muscles weaken, and coughing

4. This work is a derivative of Microbiology by OpenStax and is licensed under CC BY 4.0. Access for free at https://openstax.org/books/microbiology/pages/1-introduction

becomes less productive, which also increases the risk of developing a respiratory infection.

Mechanical Defenses

In addition to physical barriers, the body has several mechanical defenses that physically remove pathogens from the body and prevent infection. For example, the flushing action of urine carries microbes away from the body and is responsible for maintaining a sterile environment of the urinary tract.

The eyes have additional physical barriers and mechanical mechanisms for preventing infections. Eyelashes and eyelids are physical barriers that prevent dust and airborne microorganisms from reaching the surface of the eye. Any microbes or debris that make it past these physical barriers are flushed out by the mechanical action of blinking. Blinking bathes the eye in tears and washes debris away.[5] See Figure 4.3[6] for an example of eyelashes as a mechanical defense.

Figure 4.3 Eyelashes Are a Mechanical Defense Against Pathogens

Chemical Defenses

In addition to physical and mechanical defenses, our immune system uses

5. This work is a derivative of Microbiology by OpenStax and is licensed under CC BY 4.0. Access for free at https://openstax.org/books/microbiology/pages/1-introduction
6. "Eyelashes_of_a_2-month-old_baby_boy.png" by Karthik.yerramilly is licensed under CC BY-SA 4.0

several chemical defenses that inhibit microbial invaders. The term chemical mediators refers to a wide array of substances found in various fluids and tissues throughout the body. For example, sebaceous glands in the dermis secrete an oil called sebum that is released onto the skin surface through hair follicles. Sebum provides an additional layer of defense by helping seal off the pore of the hair follicle and preventing bacteria on the skin's surface from invading sweat glands and surrounding tissue. However, environmental factors can affect these chemical defenses of the skin. For example, low humidity in the winter dries the skin and makes it more susceptible to pathogens that are normally inhibited by the skin's low pH. Application of skin moisturizer restores moisture and essential oils to the skin and helps prevent dry skin from becoming infected.[7]

Other types of chemical defenses are pH levels, chemical mediators, and enzymes. For example, in the urinary tract, the slight acidity of urine inhibits the growth of potential pathogens in the urinary tract. The respiratory tract has various chemical mediators in the nasal passages, trachea, and lungs that have antibacterial properties. Enzymes in the digestive tract eliminate most microorganisms that survive the acidic environment of the stomach. However, feces, the end product of the digestive system, can still contain some microorganisms. For this reason, hand hygiene is vital after using the restroom or assisting a client with perineal care to prevent the spread of infection.[8]

7. This work is a derivative of Microbiology by OpenStax and is licensed under CC BY 4.0. Access for free at https://openstax.org/books/microbiology/pages/1-introduction
8. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0

4.4 Precautions Used to Prevent the Spread of Infection

Health care agencies use several methods to prevent the spread of infection: standard precautions and transmission-based precautions.

Standard Precautions

Standard precautions are used by health care workers during client care when contact or potential contact with blood or body fluids may occur. Standard precautions should also be used when assisting a client with activities of daily living (ADLs) and using water, soap, or lotion. Standard precautions are based on the principle that all blood, body fluids (except sweat), nonintact skin, and mucous membranes may contain transmissible infectious agents. These precautions reduce the risk of exposure for the health care worker and protect patients from potential transmission of infectious organisms.[1]

According to the Centers for Disease Control and Prevention (CDC), standard precautions include the following[2]:

- Using proper hand hygiene at the appropriate times
- Using personal protective equipment (e.g., gloves, gowns, masks, eyewear) whenever exposure to infectious agents may occur
- Implementing respiratory hygiene for staff, patients, and visitors
- Proper cleaning and sanitizing of the environment, equipment, and devices
- Handling laundry safely
- Using transmission-based precautions when indicated

1. Centers for Disease Control and Prevention. (2016, January 26). *Standard precautions for all patient care.* https://www.cdc.gov/infectioncontrol/basics/standard-precautions.html
2. Centers for Disease Control and Prevention. (2016, January 26). *Standard precautions for all patient care.* https://www.cdc.gov/infectioncontrol/basics/standard-precautions.html

Hand Hygiene

The easiest and most effective way to break the chain of infection is by using proper hand hygiene at appropriate times during patient care. Knowing when to wash your hands, how to properly wash your hands, and when to use soap and water or hand sanitizer are vital for reducing the spread of infection and keeping yourself healthy. **Hand hygiene** is the process of removing, killing, or destroying microorganisms or visible contaminants from the hands. There are two hand-hygiene techniques: handwashing with soap and water and the use of alcohol-based hand rub (ABHR), also referred to as hand hygiene gel or hand sanitizer.[3]

Health care providers' hands are the most common mode of transmission of microorganisms. As a nursing assistant, your hands will touch many people and objects when providing care. When you touch a client, their personal items, medical equipment, or their surrounding environment, you can indirectly transmit microorganisms to the client, another client, yourself, equipment, or a new environment. Microorganisms can easily be transferred from your hands to others or objects in the health care setting if proper hand hygiene practices are not followed. Consistent and effective hand hygiene is vital for breaking the chain of transmission.[4]

It is essential for all health care workers to use proper hand hygiene during specific moments of patient care[5]:

- Immediately before touching a patient
- Before performing an aseptic task, such as emptying urine from a Foley catheter bag
- Before moving from a soiled body site to a clean body site
- After touching a patient or their immediate environment

3. This work is a derivative of Introduction to Infection Prevention and Control Practices for the Interprofessional Learner by Hughes, Kenmir, St-Amant, Cosgrove, & Sharpe and is licensed under CC BY-NC 4.0
4. This work is a derivative of Introduction to Infection Prevention and Control Practices for the Interprofessional Learner by Hughes, Kenmir, St-Amant, Cosgrove, & Sharpe and is licensed under CC BY-NC 4.0
5. Centers for Disease Control and Prevention. (2019, April 29). *Hand hygiene in healthcare settings.* https://www.cdc.gov/handhygiene/

- After contact with blood, body fluids, or contaminated surfaces (with or without gloves)
- Immediately after glove removal

See Figure 4.4[6] for an illustration of the five moments of hand hygiene.

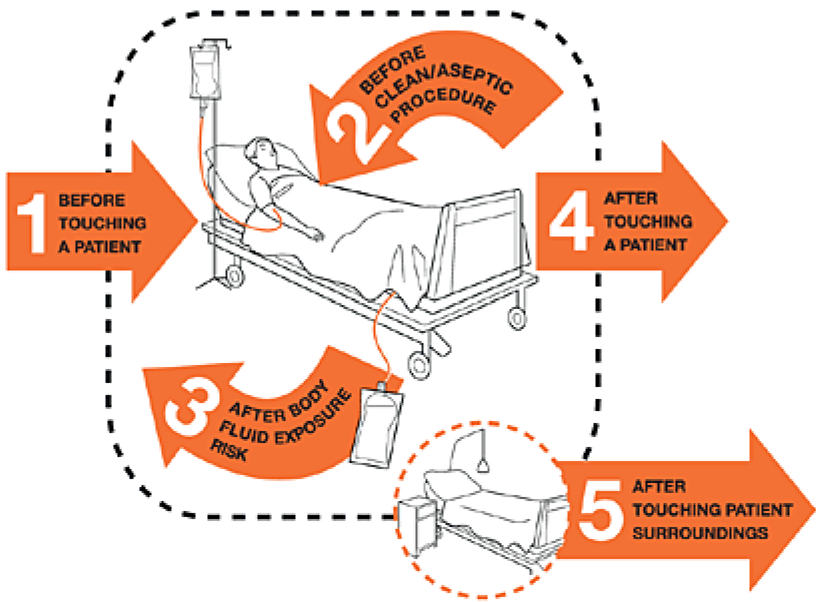


Figure 4.4 Moments of Hand Hygiene

Hand hygiene also includes health care workers keeping their nails short with tips less than 0.5 inches and no nail polish. Nails should be natural, and artificial nails or tips should not be worn. Artificial nails and chipped nail polish have been associated with a higher level of pathogens carried on the hands of health care workers despite using proper hand hygiene.[7]

Review the Moments of Hand Hygiene by clicking on the interactive activity below.

6. "5Moments_Image.gif" by World Health Organization is licensed under CC BY-NC-SA 3.0 IGO. Access for free at https://www.who.int/infection-prevention/campaigns/clean-hands/5moments/en/
7. Blackburn, L., Acree, K., Bartley, J., DiGiannantoni, E., Renner, E., & Sinnott, L. T. (2020). Microbial growth on the nails of direct patient care nurses wearing nail polish. *Oncology Nursing Forum, 47*(2), 155-164. https://doi.org/10.1188/20.onf.155-164

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=380#h5p-37

This work is a derivative of Your 4 Moments for Hand Hygiene by Michelle Hughes and is licensed under CC BY 4.0.

Proper hand hygiene includes handwashing with soap and water or the use of alcohol-based hand rub. Both procedures are described in the following sections.

HANDWASHING WITH SOAP AND WATER

Handwashing involves the use of soap and water to physically remove microorganisms from one's hands. Certain health care situations require handwashing with soap and water instead of using alcohol-based hand rub (ABHR). For example, hands must be washed with soap and water if they are visibly soiled, have been exposed to blood or body fluids, or have been exposed to *norovirus*, *C. difficile*, or *Bacillus anthracis*. The mechanical action of lathering and scrubbing with soap for a minimum of 20 seconds is vital for removing these types of microorganisms.[8]

Soap is required during handwashing to dissolve fatty materials and facilitate their subsequent flushing and rinsing with water. Soap must be rubbed on all surfaces of both hands followed by thorough rinsing and drying. Water alone is not suitable for cleaning soiled hands. The entire procedure should last 40 to 60 seconds, and soap approved by the health agency should be used.[9]

8. This work is a derivative of Introduction to Infection Prevention and Control Practices for the Interprofessional Learner by Hughes, Kenmir, St-Amant, Cosgrove, & Sharpe and is licensed under CC BY-NC 4.0
9. This work is a derivative of Introduction to Infection Prevention and Control Practices for the Interprofessional Learner by Hughes, Kenmir, St-Amant, Cosgrove, & Sharpe and is licensed under CC BY-NC 4.0

When washing with soap and water, the Centers for Disease Control and Prevention (CDC) recommends the following steps[10]:

- Wet hands with warm or cold running water and apply facility-approved soap.
- Lather hands by rubbing them together with the soap. Use the same technique as the hand rub process to clean the palms and fingers, between the fingers, the backs of the hands and fingers, the fingertips, and the thumbs.
- Scrub thoroughly for at least 20 seconds.
- Rinse hands well under clean, running water.
- Dry the hands, using a clean towel or disposable toweling, from fingers to wrists.
- Use a clean paper towel to shut off the faucet.

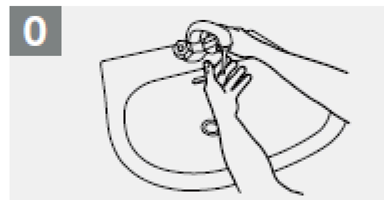
See Figure 4.5[11] for an illustration of handwashing with soap and water.

10. Centers for Disease Control and Prevention. (2016, January 26). *Standard precautions for all patient care.* https://www.cdc.gov/infectioncontrol/basics/standard-precautions.html
11. "How_To_HandWash_Poster.pdf" by World Health Organization is licensed under CC BY-NC-SA 3.0 IGO. Access for free at https://www.who.int/infection-prevention/campaigns/clean-hands/5moments/en/

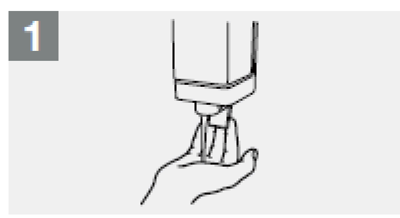
How to Handwash?

WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB

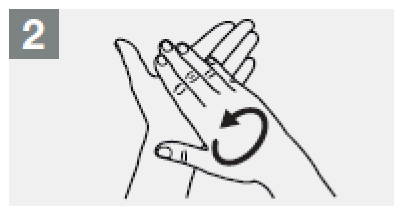
Duration of the entire procedure: 40-60 seconds



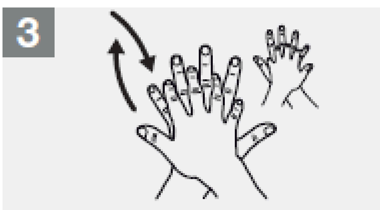
Wet hands with water;



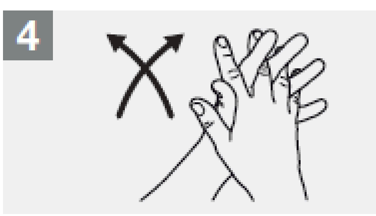
Apply enough soap to cover all hand surfaces;



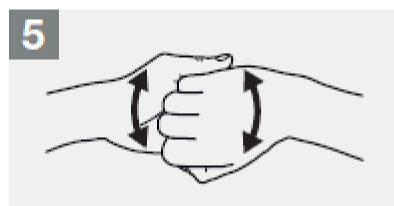
Rub hands palm to palm;



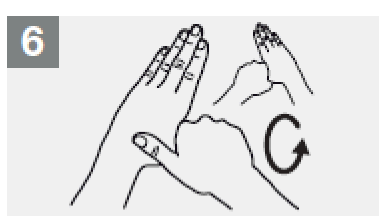
Right palm over left dorsum with interlaced fingers and vice versa;



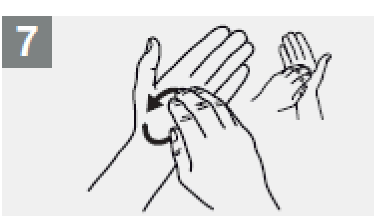
Palm to palm with fingers interlaced;



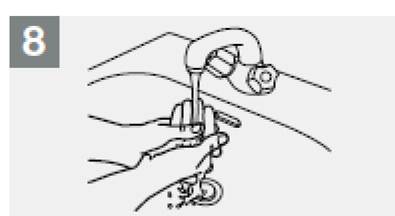
Backs of fingers to opposing palms with fingers interlocked;



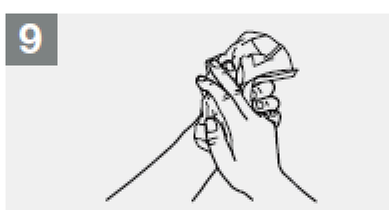
Rotational rubbing of left thumb clasped in right palm and vice versa;



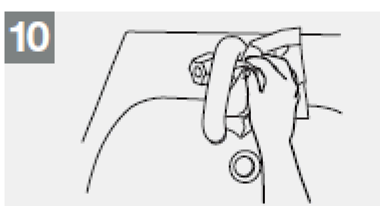
Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;



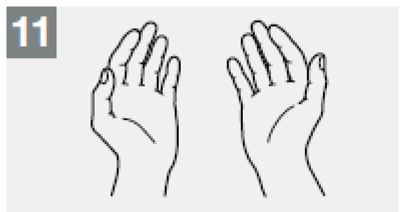
Rinse hands with water;



Dry hands thoroughly with a single use towel;



Use towel to turn off faucet;



Your hands are now safe.

Patient Safety
A World Alliance for Safer Health Care

SAVE LIVES
Clean Your Hands

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this document. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

WHO acknowledges the Hôpitaux Universitaires de Genève (HUG), in particular the members of the Infection Control Programme, for their active participation in developing this material.

May 2009

Figure 4.5 How to Handwash with Soap and Water

See the "Skills Checklist: Hand Hygiene With Soap and Water" section later in this chapter for a checklist of steps and an associated demonstration video of this procedure. Common safety considerations and errors when washing hands are described in the following box.

Safety Considerations[12]

- Always wash hands with soap and water if hands are visibly soiled.
- When working with clients where *C. difficile*, *norovirus*, or *Bacillus anthracis* is suspected or confirmed, soap and water must be used. It is more effective in physically removing the *C. difficile* spores compared to ABHR, which is not as effective at penetrating the spores.
- Friction and rubbing are required to remove transient bacteria, oil, and debris from hands.
- Always use soap and water if hands are exposed to blood, body fluids, or other body substances.
- Multistep rubbing techniques using soap and water are required to promote coverage of all surfaces on hands.

Common Errors When Washing Hands With Soap and Water[13]

- Not using enough soap to cover all surfaces of the hands and wrists.
- Not using friction when washing hands.
- Not washing hands long enough. The mechanical action of

12. This work is a derivative of Introduction to Infection Prevention and Control Practices for the Interprofessional Learner by Hughes, Kenmir, St-Amant, Cosgrove, & Sharpe and is licensed under CC BY-NC 4.0
13. This work is a derivative of Introduction to Infection Prevention and Control Practices for the Interprofessional Learner by Hughes, Kenmir, St-Amant, Cosgrove, & Sharpe and is licensed under CC BY-NC 4.0

lathering and scrubbing should be a minimum of 20 seconds, and the entire procedure should last 40 to 60 seconds.

- Missing areas such as the fingernails, wrists, backs of hands, and thumbs.
- Not removing all soap from hands and wrists.
- Shaking water off hands.
- Not thoroughly drying the hands.
- Drying hands from wrists to fingers or in both directions.

Practice your knowledge by clicking on this interactive learning activity.

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=380#h5p-38

This work is a derivative of the YouTube Hand Washing Video by Michelle Hughes and is licensed under CC BY-NC 4.0.

ALCOHOL-BASED HAND RUB

When performing hand hygiene using the alcohol-based hand rub (ABHR) technique, a liquid, gel, or foam alcohol-based solution is used. ABHR is the preferred method for hand hygiene when soap and water handwashing is not required. It reduces the number of transient microorganisms on hands and is more effective for preventing healthcare-acquired infections (HAIs) caused by

Methicillin-resistant Staphylococcus aureus (MRSA) and *Vancomycin-resistant enterococcus* (VRE). Hand hygiene with ABHR should be performed in front of the client prior to the beginning of care and at the end of the interaction. ABHR provided by the agency should be used with a 70–90% alcohol concentration.[14]

The benefits of ABHR include the following[15]:

- It kills the majority of microorganisms (including viruses) from hands.
- It requires less time than soap and water handwashing.
- It provides better skin tolerability and reduces skin irritation because it contains emollients.
- It is easy to use and available at the point of care (i.e., where three elements of the client, the health care provider, and care involving the client occur together).

Read safety considerations and common errors when using ABHR in the following box. See the "Skills Checklist: Hand Hygiene With Alcohol-Based Hand Sanitizer" section later in this chapter for a checklist of steps and an associated demonstration video of this procedure.

Safety Considerations[16]

- Do not use ABHR in combination with soap and water because it may increase skin irritation.
- Use ABHR that contains emollients (oils) to help reduce skin irritation and overdrying.

14. Centers for Disease Control and Prevention. (2016, January 26). *Standard precautions for all patient care.* https://www.cdc.gov/infectioncontrol/basics/standard-precautions.html
15. Centers for Disease Control and Prevention. (2016, January 26). *Standard precautions for all patient care.* https://www.cdc.gov/infectioncontrol/basics/standard-precautions.html
16. Centers for Disease Control and Prevention. (2016, January 26). *Standard precautions for all patient care.* https://www.cdc.gov/infectioncontrol/basics/standard-precautions.html

- Allow hands to dry completely before initiating tasks (e.g., touching the client or the environment or applying clean gloves).
- Use ABHR for all moments of hand hygiene if soap and water are not required.
- DO NOT use ABHR if hands are visibly soiled, have been exposed to blood or body fluids, or the client is suspected to have *C. difficile*, *norovirus*, or *Bacillus anthracis*.
- Only use ABHR supplied by the facility.

Common Errors When Performing an ABHR[17]

- Not letting hands air dry (for example, rubbing one's hands on pants to dry it off).
- Shaking hands to dry.
- Applying too much alcohol-based solution.
- Not applying enough alcohol-based solution.
- Not rubbing hands long enough (a minimum of 20 seconds) and until hands are dry.
- Missing areas such as the fingernails, wrists, backs of the hands, and thumbs.

Practice your knowledge by clicking on this interactive learning activity.

17. Centers for Disease Control and Prevention. (2016, January 26). *Standard precautions for all patient care.* https://www.cdc.gov/infectioncontrol/basics/standard-precautions.html

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=380#h5p-20

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=380#h5p-21

This work is a derivative of Performing an Alcohol-Based Hand Rub by Michelle Hughes and is licensed under CC BY-NC 4.0.

Respiratory Hygiene and Other Hygienic Practices

Respiratory hygiene should be used by any person with signs of illness, including cough, congestion, or increased production of respiratory secretions to prevent the spread of infection. Respiratory hygiene refers to coughing or sneezing into the inside of one's elbow or covering one's mouth/nose with a tissue when coughing and promptly disposing of used tissues. Hand hygiene should be immediately performed after contact with one's respiratory secretions. A coughing person should also wear a surgical mask to contain secretions.[18]

Additional hygiene measures are also used to prevent the spread of infection. For example, regularly changing bed linens, towels, and hospital gowns

18. Centers for Disease Control and Prevention. (2016, January 26). *Standard precautions for all patient care.* https://www.cdc.gov/infectioncontrol/basics/standard-precautions.html

eliminates potential reservoirs of bacteria. Gripper socks should be removed before patients get into bed to prevent pathogens from the floor from being transferred to the patient's bed linens.

Mobile devices should be cleaned regularly. Research has shown that cell phones and mobile devices carry many pathogens and are dirtier than a toilet seat or the bottom of a shoe. Patients, staff, and visitors routinely bring mobile devices into health care facilities that can cause the spread of infection. Mobile devices should be frequently wiped with disinfectant.

Disinfection and Sterilization

Disinfection and sterilization are procedures used to remove harmful pathogens from equipment and the environment to decrease the risk of spreading infection. **Disinfection** is the removal of microorganisms, but it does not destroy all spores and viruses. **Sterilization** destroys all pathogens on equipment or in the environment, including spores and viruses, and includes methods such as steam, boiling water, dry heat, radiation, and chemicals. Because of the harshness of sterilization methods, skin can only be disinfected and not sterilized.[19]

Asepsis refers to the absence of infectious material or infection. **Surgical asepsis** is the absence of all microorganisms during any type of invasive procedure, such as during surgery or heart catheterizations. Sterilization is performed on equipment used during invasive procedures. As a nursing assistant, you may assist a registered nurse during a procedure requiring sterile technique; however, performing sterile procedures independently is not in the scope of practice for nursing assistants.

In long-term care and other health care settings other than surgery, medical asepsis is used. **Medical asepsis** refers to techniques used to prevent the transfer of microorganisms from one person or object to another but do not

19. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0

eliminate all microorganisms. Nursing assistants implement medical asepsis in the following ways:

- Performing hand hygiene at the appropriate moments of patient care. (See previous Figure 4.4.)
- Using a barrier when placing clean linens, wash basins, and other items on a shared surface such as the countertop in a resident's room.
- Pulling the privacy curtain when one resident has a droplet-transmitted infection to protect transmission to the other resident in a shared room.
- Cleaning equipment (such as blood pressure cuffs) between use on residents.
- Starting with "cleaner" areas of the body when assisting with care and then moving to areas with higher levels of microorganisms. For example, when bathing a client, the face is washed first, followed by the upper body and then finishing with perineal care. (**Perineal care** involves washing the genital and rectal areas of the body.)

Laundry

When handling dirty linens, textiles, and patients' clothing, follow agency policy regarding transport to prevent the potential spread of infection. The Centers for Disease Control and Prevention (CDC) states that contaminated textiles and fabrics should be handled with minimal agitation to avoid contamination of air, surfaces, and other individuals. They should be bagged at the point of use, and leak-resistant bags should be used for textiles and fabrics contaminated with blood or body substances.[20]

Transmission-Based Precautions

When providing care for individuals with known or suspected infections, additional precautions are used in addition to the previously discussed standard precautions. Certain types of pathogens and communicable

20. Centers for Disease Control and Prevention. (2020, April 29). *Infection control*. https://www.cdc.gov/infectioncontrol/index.html

diseases are easily transmitted to others and require additional precautions to interrupt the spread of infectious agents to health care workers and other clients. For example, *Coronavirus* disease (COVID-19), *C. difficile* (C-diff), *Methicillin-resistant Staphylococcus aureus (*MRSA), *Vancomycin-resistant enterococci* (VRE), *Respiratory Syncytial Virus* (RSV), measles, and tuberculosis (TB) require transmission-based precautions.

Transmission-based precautions (commonly referred to as isolation precautions) use specific types of personal protective equipment (PPE) and practices based on the pathogen's mode of transmission. It is vital for nursing assistants to understand what PPE should be used in specific client care situations, which is determined by the pathogen's mode of transmission and their possible risk of exposure.[21] Transmission-based precautions include three categories: contact, droplet, and airborne precautions. Read more about each type of transmission-based precaution in Table 4.1.

Table 4.1 Categories of Transmission-Based Precautions[22,23,24]

21. This work is a derivative of Introduction to Infection Prevention and Control Practices for the Interprofessional Learner by Hughes, Kenmir, St-Amant, Cosgrove, & Sharpe and is licensed under CC BY-NC 4.0
22. Office of Infectious Disease and HIV/AIDS Policy. (n.d.). *Health care-associated infections.* U.S. Department of Health & Human Services. https://www.hhs.gov/oidp/topics/health-care-associated-infections/index.html
23. This work is a derivative of Introduction to Infection Prevention and Control Practices for the Interprofessional Learner by Hughes, Kenmir, St-Amant, Cosgrove, & Sharpe and is licensed under CC BY-NC 4.0
24. Siegel, J. D., Rhinehart, E., Jackson, M., Chiarello, L., & Healthcare Infection Control Practices Advisory Committee. (2019, July 22). *2007 guideline for isolation precautions: Preventing transmission of infectious agents in healthcare settings.* Centers for Disease Control and Prevention. https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

Transmission-Based Precaution	PPE Required	Special Considerations
Contact	Gloves and gown, possibly face shield	Used for clients with known or suspected infections such as *C-difficile* (C-diff), *methicillin-resistant staphylococcus aureus* (MRSA), *vancomycin resistant enterococcus* (VRE), or *norovirus* transmitted by touch (e.g., drainage from wounds or fecal incontinence). Contact precautions should be used when there is expected contact with the source of the pathogen or any surfaces within the resident's room. For example, MRSA in a client's wound transmits with direct contact with the wound, so wearing gloves and a gown when entering the room with a meal tray is typically sufficient. However, MRSA in a client's urine could be accidentally splashed onto one's mucous membrane when emptying the bag of an indwelling urinary catheter, so a face shield is also necessary for this task, in addition to wearing gloves and a gown.
Droplet	Gloves and a mask	Used for clients with a diagnosed or suspected pathogen that is spread in small droplets from sneezing or other oral and nasal secretions, such as influenza or pertussis. Droplets can travel six feet, so using barriers such as privacy curtains and closing doors can also prevent the spread of infection to others.
Airborne	Gloves and respirator	Used for clients with diagnosed or suspected pathogens spread by very small airborne particles from nasal and oral secretions that can float long distances through the air, such as measles and tuberculosis. Respirators are specially designed masks that fit closely on the face and filter out small particles, including the virus that causes COVID. Clients must be placed in a room with specialized air handling equipment found in doctors' offices and hospitals. Residents in long-term care settings suspected of having an airborne illness should be transferred immediately to prevent the spread of infection to other residents.

Signage for Transmission-Based Precautions

When a resident has an infectious illness requiring transmission-based precautions, a sign is placed on their door and a cart of PPE supplies is placed

nearby. Signs vary by facility but look similar to the image in Figure 4.6.[25] Due to HIPAA regulations, the type of the pathogen and the source cannot be displayed publicly, so the sign instructs anyone wishing to enter the room to ask the nurse first. Additional information regarding the type and source of the infection can be found in the client's nursing care plan. After you become aware of the pathogen, the source, and the required PPE, you can safely enter the room. If you are unsure about any aspect of PPE required or your risk of exposure, talk to the nurse before entering the room or providing care.

25. "contact-precautions-sign-P.pdf" by U.S. Department of Health and Human Services and Centers for Disease Control and Prevention is licensed in the Public Domain. Access for free at https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html#anchor_1564058318

Clean their hands, including before entering and when leaving the room.

PROVIDERS AND STAFF MUST ALSO:

Put on gloves before room entry.
Discard gloves before room exit.

Put on gown before room entry.
Discard gown before room exit.

Use dedicated or disposable equipment.
Clean and disinfect reusable equipment before use on another person.

CS19-306149-A

Figure 4.6 Example of Isolation Precautions Sign

View the following YouTube video from the University of Iowa about isolation precautions in a health care setting: Standard and Isolation Precautions.

4.5 Personal Protective Equipment (PPE)

In health care settings, **personal protective equipment (PPE)** refers to specialized clothing or equipment used to prevent the spread of infection, including gloves, gowns, facial protection (masks and eye protection), and respirators. PPE is a barrier that protects the health care worker from exposure to infectious agents and also prevents the transmission of microorganisms to other individuals including staff, patients, and visitors.

Gloves

Gloves are disposable, one-time-use coverings that protect the hands of health care providers. See Figure 4.7[1] for an image of nonsterile medical gloves in various sizes in a health care setting. Gloves are used to protect the hands of a health care worker from coming into contact with a client's potentially infected body fluids and to protect patients from coming into contact with potential contaminants on health care workers' hands during certain procedures and treatments. Gloves should also be worn by a health care worker when there is a risk of transmitting their own body fluids from nonintact skin on their hands to other individuals. However, gloves should not be worn for routine activities such as taking vital signs or transferring a client in a wheelchair unless indicated due to transmission-based precautions.

1. "Surgery Centre Accriditation.jpg" by Accredia is licensed under CC BY-SA 4.0

Figure 4.7 Gloves

Gloves are typically made from latex, nitrile, and vinyl. Many people are allergic to latex, so be sure to check for latex allergies for the patient and other members of the health care team. Most gloves are not hand-specific and can be worn on either the left or right hand. Gloves come in a variety of sizes such as small, medium, large, and extra large and should have a snug fit, not too tight or too loose, to provide better protection to the health care provider.[2]

Gloves should always be used in combination with proper hand hygiene that is performed prior to applying gloves and repeated again after gloves are removed. Gloves are task-specific and should not be worn for more than one task or procedure on the same client because some tasks may have a greater concentration of microorganisms than others. For example, gloves are worn to assist a client with incontinent care, but gloves should be removed, hand hygiene performed, and new gloves applied before assisting with oral care. Gloves should never be reused or washed to be reused. Reusing gloves has been linked with the transmission of infectious microorganisms.

Gloves should never replace hand hygiene for several reasons[3]:

2. This work is a derivative of Introduction to Infection Prevention and Control Practices for the Interprofessional Learner by Hughes, Kenmir, St-Amant, Cosgrove, & Sharpe and is licensed under CC BY-NC 4.0
3. This work is a derivative of Introduction to Infection Prevention and Control Practices for the Interprofessional Learner by Hughes, Kenmir, St-Amant, Cosgrove, & Sharpe and is licensed under CC BY-NC 4.0

- Gloves may have imperfections such as holes or cracks that are not visible.
- Hands may have become contaminated while removing the gloves.
- Gloves may have become damaged while wearing.

Fingernails should be short prior to applying gloves so they do not puncture the gloves. Put on (don) gloves after hands are completely dry after performing hand hygiene. There is no specific method for putting on gloves, but care should be taken when donning gloves to avoid tearing. Gloves should be applied so they completely cover the wrists. Gloves must be removed carefully, followed by proper hand hygiene, to prevent the spread of infection.[4]

REMOVING GLOVES

See Figure 4.8[5] for an illustration of properly removing gloves. Hand hygiene should be performed following glove removal to ensure the hands will not carry potentially infectious agents that might have penetrated through unrecognized tears or contaminated the hands during glove removal.

Properly removing gloves includes the following steps[6]:

- Grasp the outside of one glove near the wrist. Do not touch your skin.
- Peel the glove away from your body, pulling it inside out.
- Hold the removed glove in your gloved hand.
- Put your fingers inside the glove at the top of your wrist and peel off the second glove.
- Turn the second glove inside out while pulling it away from your body, leaving the first glove inside the second.

4. This work is a derivative of Introduction to Infection Prevention and Control Practices for the Interprofessional Learner by Hughes, Kenmir, St-Amant, Cosgrove, & Sharpe and is licensed under CC BY-NC 4.0
5. "poster-how-to-remove-gloves.pdf" by Centers for Disease Control and Prevention is in the Public Domain. Access for free at https://www.cdc.gov/vhf/ebola/resources/posters.html
6. Siegel, J. D., Rhinehart, E., Jackson, M., Chiarello, L., & Healthcare Infection Control Practices Advisory Committee. (2019, July 22). *2007 guideline for isolation precautions: Preventing transmission of infectious agents in healthcare settings.* Centers for Disease Control and Prevention. https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

- Dispose of the gloves safely. Do not reuse.
- Perform hand hygiene immediately after removing the gloves.

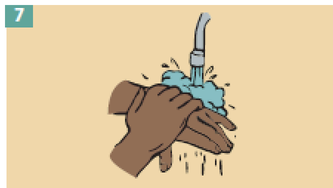


Figure 4.8 How to Remove Gloves to Prevent Contamination

Review infection prevention and control practices related to glove usage in the following interactive activity.

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=397#h5p-23

This work is a derivative of Infection Prevention and Control Practices by Michelle Hughes and Kendra Allen is licensed under CC BY 4.0.

Isolation Gowns

Isolation gowns are protective garments worn to protect clothing from the splashing or spraying of body fluids and reduce the transmission of microorganisms. Isolation gowns can be disposable or reusable. The gowns should have long sleeves with a snug fit at the wrist, cover both the front and the back of the body from the neck to the thighs, and overlap at the back.

Gloves should fit over the cuffs of the gown. Gowns should fasten at the neck and waist using ties, snaps, or Velcro.[7]

Disposable gowns are made from materials that make them resistant to fluids. Reusable gowns are made of tightly woven cotton or polyester and are chemically finished to improve their ability to be fluid resistant; they are laundered after each use. Gowns are considered task-specific and should be changed if they become heavily soiled or damaged. Isolation gowns should be put on immediately prior to providing client care and should be removed immediately after care is completed before leaving the room. After use, gowns should be discarded into an appropriate receptacle for disposal or to

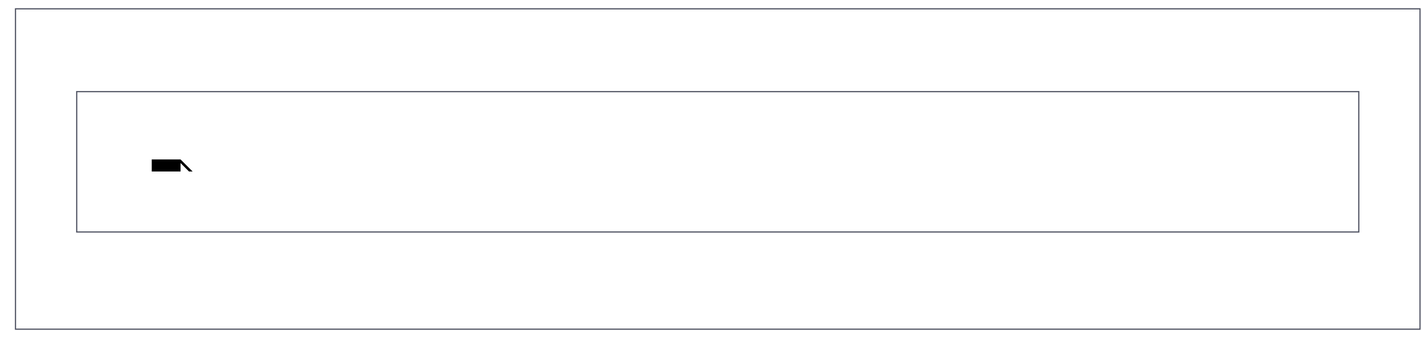
7. This work is a derivative of Introduction to Infection Prevention and Control Practices for the Interprofessional Learner by Hughes, Kenmir, St-Amant, Cosgrove, & Sharpe and is licensed under CC BY-NC 4.0

be laundered if the gown is reusable. See Figure 4.9[8] for an image of an isolation gown.

Figure 4.9 Isolation Gown

Special care should be taken when removing the gown to prevent contamination of clothing and skin. The front of the gown is always considered to be contaminated. Ties at the front are considered contaminated, but ties at the side and the back are considered uncontaminated.[9]

See the "Donning/Doffing PPE" checklists later in this chapter for steps for proper removal of gowns. Review information related to using isolation gowns in the following interactive activity.



8. "U.S. Navy Doctors, Nurses and Corpsmen Treat COVID Patients in the ICU Aboard USNS Comfort (49825651378).jpg" by Navy Medicine is in the Public Domain
9. This work is a derivative of Introduction to Infection Prevention and Control Practices for the Interprofessional Learner by Hughes, Kenmir, St-Amant, Cosgrove, & Sharpe and is licensed under CC BY-NC 4.0

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=397#h5p-24

This work is a derivative of Important Considerations When Wearing Gowns by Audrey Kenmir and is licensed under CC BY 4.0.

Eye Protection

Eye protection in health care settings includes face shields, visors attached to masks, and goggles that are used to protect the eyes from blood or body fluids. Eye protection should be worn by health care workers during patient care when there may be splashing or spraying of body fluids or within six feet of a coughing client. For example, eye protection is worn when emptying a urinary catheter or assisting a nurse in irrigating a wound or suctioning a client's airway.

Eye protection can be disposable, like face shields, or reusable, like eye goggles. If eye protection is reusable, it should be cleaned before reuse. Face shields and visors attached to masks offer better visibility than goggles. Eye protection should fit comfortably and securely while allowing for visual acuity. Eyeglasses can be worn under face shields or goggles.[10] See Figure 4.10[11] for an image of eye goggles with and without a face shield.

10. This work is a derivative of Introduction to Infection Prevention and Control Practices for the Interprofessional Learner by Hughes, Kenmir, St-Amant, Cosgrove, & Sharpe and is licensed under CC BY-NC 4.0
11. "IMG_2021-scaled" and "IMG_2026-scaled" by unknown author are licensed under CC BY-NC-4.0. Access for free at https://ecampusontario.pressbooks.pub/introductiontoipcp/chapter/eye-protection/

Figure 4.10 Eye Goggles With and Without a Face Shield

Review information related to the use of eye protection in the following learning activity.

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=397#h5p-25

This work is a derivative of Important Considerations When Wearing Eye Protection by Michelle Hughes and is licensed under CC BY-NC 4.0.

Masks

Masks are protective coverings worn by health care providers to protect the mucous membranes of their nose and mouth. In long-term care settings, masks are typically secured by elastic loops around the ears. The top edge of the mask has a bendable strip to secure the seal of the mask over the bridge of the nose. Some situations require masks to be combined with a face shield

or a visor that covers the eyes. See Figure 4.11[12] for an image of masks used with eyeglasses and an eyeshield.

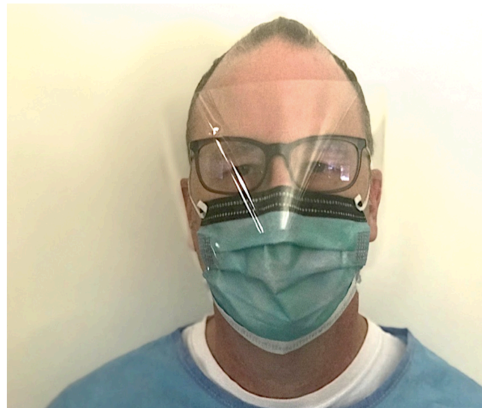


Figure 4.11. Medical Mask With and Without an Eye Shield

Medical masks should be worn when providing care that may cause splashing or spraying of blood or body fluids or within six feet of a client who is coughing or has been placed in droplet precautions. Medical masks should also be worn by health care providers who are coughing to prevent transmission of exhaled respiratory droplets to clients.

Medical masks can differ in their filtration effectiveness and the way in which they fit. Single-use disposable medical masks are effective when providing care to most clients and should be changed when damp or soiled. When medical masks become moist, they may not provide an effective barrier to microorganisms. A medical mask, when properly worn, should fit snugly over the nose, mouth, and under the chin so that microorganisms and body fluids cannot enter or exit through the sides of the mask. If the health care worker wears glasses, the glasses should be placed over the top edge of the mask. This will help prevent the glasses from becoming foggy as the person wearing the mask exhales.

12. "Screen-Shot-2021-05-05-at-3.57.19-PM" and "Screen-Shot-2021-05-05-at-3.57.41-PM" by unknown author are licensed under CC BY-NC 4.0. Access for free at https://ecampusontario.pressbooks.pub/introductiontoipcp/chapter/masks/

REMOVING FACEMASKS

Like the isolation gown, the front of the mask is considered contaminated. The mask should be removed by taking the ear loop off and placing it in the appropriate disposal area. It is important to properly remove masks to avoid contamination. See Figure 4.12[13] for an illustration of how to remove a facemask according to the CDC. See the "Donning/Doffing PPE With a Mask and Face Shield or Goggles" checklist for more details.

13. "fs-facemask-dos-donts.pdf" by Centers for Disease Control and Prevention is in the Public Domain. Access for free at https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html

Facemask Do's and Don'ts

For Healthcare Personnel

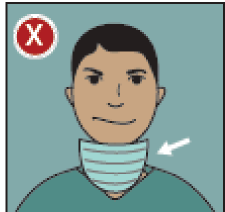
When putting on a facemask

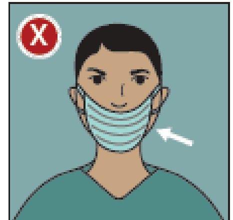
Clean your hands and put on your facemask so it fully covers your mouth and nose.

DO secure the elastic bands around your ears.

DO secure the ties at the middle of your head and the base of your head.

When wearing a facemask, don't do the following:

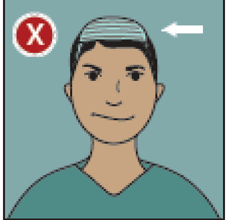




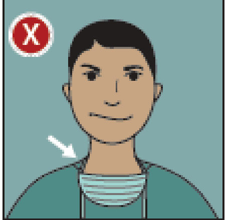
DON'T wear your facemask under your nose or mouth.

DON'T allow a strap to hang down. DON'T cross the straps.

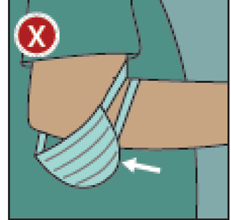
DON'T touch or adjust your facemask without cleaning your hands before and after.



DON'T wear your facemask on your head.



DON'T wear your facemask around your neck.



DON'T wear your facemask around your arm.

When removing a facemask

Clean your hands and remove your facemask touching only the straps or ties.

DO leave the patient care area, then clean your hands with alcohol-based hand sanitizer or soap and water.

DO remove your facemask touching ONLY the straps or ties, throw it away*, and clean your hands again.

*If implementing limited-reuse: Facemasks should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. Folded facemasks can be stored between uses in a clean, sealable paper bag or breathable container.

Additional information is available about how to safely put on and remove personal protective equipment, including facemasks: https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html.

cdc.gov/coronavirus

CS 316488A June 2, 2020 11:30 AM

Figure 4.12 Removing Facemasks

Review information on wearing medical masks in the following interactive learning activities.

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=397#h5p-26

This work is a derivative of Important Considerations When Wearing Medical Masks by Michelle Hughes and is licensed under CC BY 4.0.

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=397#h5p-27

This work is a derivative of Important Considerations When Wearing Medical Masks by Michelle Hughes and is licensed under CC BY 4.0.

Respirators and PAPRs

Residents requiring airborne transmission precautions are transferred to a hospital immediately upon suspicion or confirmation of an airborne illness as respiratory protection used with airborne transmission precautions requires special equipment. Respirator masks with N95 or higher filtration are worn by health care professionals to prevent inhalation of infectious small airborne particles. It is important to apply, wear, and remove respirators appropriately to avoid contamination. A user-seal check should be performed by the wearer each time a respirator is donned to minimize air leakage around the

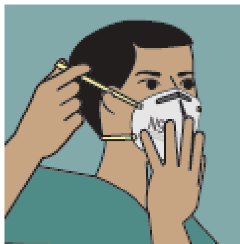
facepiece. See Figure 4.13[14] for CDC recommendations when wearing disposable respirators.

14. "fs-respirator-on-off.pdf" by Centers for Disease Control and Prevention is in the Public Domain. Access for free at https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html

Respirator On / Respirator Off

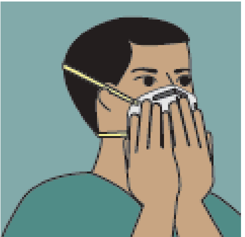
When you put on a disposable respirator

Position your respirator correctly and check the seal to protect yourself from COVID-19.

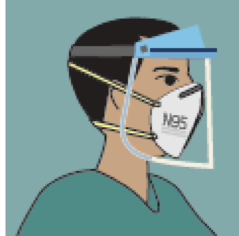


Cup the respirator in your hand. Hold the respirator under your chin with the nose piece up. The top strap (on single or double strap respirators) goes over and rests at the top back of your head. The bottom strap is positioned around the neck and below the ears.

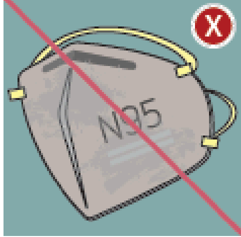
Place your fingertips from both hands at the top of the metal nose clip (if present). Slide fingertips down both sides of the metal strip to mold the nose area to the shape of your nose.



Place both hands over the respirator, take a quick breath in to check the seal. Breathe out. If you feel a leak when breathing in or breathing out, there is not a proper seal.

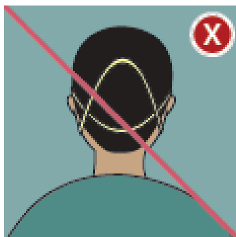


Select other PPE items that do not interfere with the fit or performance of your respirator.

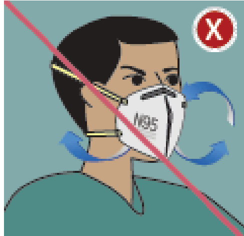


Do not use a respirator that appears damaged or deformed, no longer forms an effective seal to the face, becomes wet or visibly dirty, or if breathing becomes difficult.

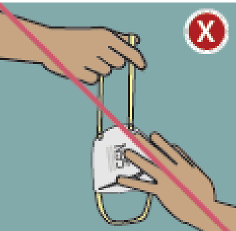
Do not allow facial hair, jewelry, glasses, clothing, or anything else to prevent proper placement or to come between your face and the respirator.



Do not crisscross the straps.

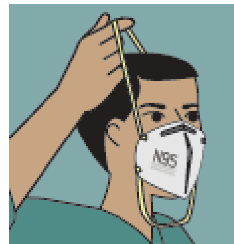


Do not wear a respirator that does not have a proper seal. If air leaks in or out, ask for help or try a different size or model.



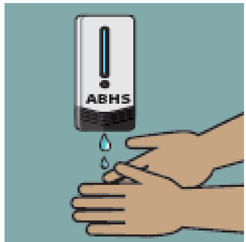
Do not touch the front of the respirator during or after use! It may be contaminated.

When you take off a disposable respirator



Remove by pulling the bottom strap over back of head, followed by the top strap, without touching the respirator.

Discard in a waste container.



Clean your hands with alcohol-based hand sanitizer or soap and water.

Employers must comply with the OSHA Respiratory Protection Standard, 29 CFR 1910.134, which includes medical evaluations, training, and fit testing.

Additional information is available about how to safely put on and remove personal protective equipment, including respirators:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html

cdc.gov/coronavirus

CS 317033A June 9, 2020 3:07 PM

Figure 4.13 How to Put On and Take Off a Respirator Mask

A newer piece of equipment used for respiratory protection is the powered air-purifying respirator (PAPR). A **PAPR** is an air-purifying respirator that uses a blower to force air through filter cartridges or canisters into the breathing zone of the wearer. This process creates an air flow inside either a tight-fitting facepiece or loose-fitting hood or helmet, providing a higher level of protection against aerosolized pathogens, such as COVID-19, during respiratory suctioning. See Figure 4.14[15] for an example of PAPR in use.

Figure 4.14 PAPR

Resident Considerations During Isolation Precautions

There are a lot of things to consider when preventing the spread of infection among residents, staff, equipment, and surfaces. It is important to think about the tasks you will be performing for residents and determine ahead of time what you might be exposed to in order to select the appropriate PPE. The perspective and needs of clients placed in isolation precautions should also be considered. PPE makes communication more difficult by hiding facial expressions and making hearing more difficult, and therapeutic touch is less personal when wearing gloves. Caregivers often spend less time interacting with clients in transmission-based precautions due to the labor intensiveness of putting on and taking off PPE, resulting in clients often developing feelings of loneliness and social isolation due to less frequent interactions. Try to keep

15. "PAPRs_in_use_01.jpg" by Ca.garcia.s is licensed under CC BY-SA 4.0

the resident’s routine as normal as possible and apply extra effort to interact with the client.

When transporting a client with transmission-based precautions within a facility, keep these principles in mind[16]:

- Limit transport for essential purposes only, such as diagnostic and therapeutic procedures that cannot be performed in the patient’s room.
- When transporting, use appropriate barriers on the patient consistent with the route and risk of transmission. For example, for a resident with a skin infection with MRSA, be sure the area is covered.
- Notify health care personnel in the receiving area of the impending arrival of the patient and of the precautions necessary to prevent transmission.

16. Siegel, J. D., Rhinehart, E., Jackson, M., Chiarello, L., & Healthcare Infection Control Practices Advisory Committee. (2019, July 22). *2007 guideline for isolation precautions: Preventing transmission of infectious agents in healthcare settings.* Centers for Disease Control and Prevention. https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

4.6 Blood-borne Pathogen Standard

Blood-borne pathogens are infectious microorganisms in blood and body fluids that can cause disease. These pathogens include, but are not limited to, hepatitis B (HBV), hepatitis C (HCV), and human immunodeficiency virus (HIV). Workers in many health-related occupations, including nursing assistants and other health care personnel, are at risk for exposure to blood-borne pathogens.

Needlesticks and other sharps-related injuries may expose workers to blood-borne pathogens. As a nursing assistant, your highest risk for blood-borne exposure is during shaving and any related disposal of the razor. Typically, residents use electric razors that have low risk of causing any open cuts, but you should always wear gloves when shaving a resident. Any disposable razor or objects that can cause a break in the skin, such as broken glass or needles, should be disposed of in a sharps container.[1] See Figure 4.15[2] for an image of a sharps container.

Figure 4.15 Sharps Container

Health care employers must follow OSHA's guidelines for handling blood

1. Occupational Safety and Health Administration. (n.d.). *Bloodborne pathogens and needlestick prevention.* United States Department of Labor. https://www.osha.gov/bloodborne-pathogens
2. "Sharps Container" by Landon Cerny is licensed under CC BY 4.0

called the "Blood-borne Pathogens Standard." If you handle a spill of blood or body fluids, you should wear a face shield, gown, and gloves. You should receive training during your orientation at an agency on how to properly handle a blood spill and the PPE and cleaning solutions available. See Figure 4.16[3] for an image of a typical blood spill kit.

Figure 4.16 Blood Spill Kit

If you do experience an exposure to a patient's blood or body fluids, follow agency policy and wash/flush the area and notify the nurse supervisor. Part of OSHA's "Blood-borne Pathogens Standard" is to complete a postexposure assessment to determine if additional medical treatment is required. It is extremely important that this assessment occurs immediately after your exposure. The standard also requires your employer to offer the vaccine series for hepatitis B and hepatitis C at no cost to you if you have not previously received them.

- To read more information on OSHA's Blood-borne Pathogens Standard, visit OSHA's FactSheet PDF.

3. "Blood Spill Kit" by Landon Cerny is licensed under CC BY 4.0

4.7 Signs and Symptoms of Infection

Nursing assistants spend a great deal of time with clients, so it is important to recognize early signs and symptoms of infection and report them to the nurse. While there are specific symptoms associated with specific types of infection, there are some general symptoms that can occur with all infections. These general symptoms include a feeling of **malaise** (i.e., a feeling of discomfort, illness, or lack of well-being), headache, fever, and lack of appetite.

A **fever** is a common sign of inflammation and infection. A temperature of 38 degrees Celsius (100.4 degrees F) is generally considered a low-grade fever, and a temperature of 38.3 degrees Celsius (101 degrees F) is considered a fever. Fever is part of the body's nonspecific immune response and can be beneficial in destroying pathogens. However, extremely elevated temperatures can cause cell and organ damage, and prolonged fever can cause dehydration.

Infection raises the metabolic rate, which causes an increased heart rate. The respiratory rate may also increase as the body rids itself of carbon dioxide created during increased metabolism. If either of these conditions are noted, they should be reported to the nurse right away.

As an infection develops, the lymph nodes that drain that area often become enlarged and tender. The swelling indicates the lymph nodes are fighting the infection.

If a skin infection is developing, general signs of inflammation, such as redness, warmth, swelling, and tenderness, will occur at the site. As white blood cells migrate to the site of infection, yellow or green drainage (i.e., purulent drainage) may occur.

Some viruses, bacteria, and toxins cause gastrointestinal inflammation, resulting in loss of appetite, nausea, vomiting, and diarrhea.

See Table 4.7 for a comparison of expected findings in body systems versus unexpected findings that can indicate an infection and require notification of the nurse and/or health care provider.

Table 4.7 Expected Versus Unexpected Findings Related to Infection[1]

Assessment	Expected Findings	Unexpected Findings to Report to the Nurse
Vital Signs	Within normal range	New temperature over 100.4 F or 38 C or lower than the patient's normal.
Neurological	Within baseline level of consciousness	New confusion and/or worsening level of consciousness.
Wound or Incision	Progressive healing of a wound with no signs of infection	New redness, warmth, tenderness, or purulent drainage from a wound.
Respiratory	No cough or production of sputum	New cough and/or productive cough of purulent sputum. New shortness of breath.
Genitourinary	Urine clear and light yellow without odor	Malodorous, cloudy, or bloody urine, with increased frequency, urgency, or pain with urination.
Gastrointestinal	Good appetite and food intake; feces formed and brown	Loss of appetite. Nausea, vomiting, or diarrhea. Discolored or unusually malodorous feces.
		*CRITICAL CONDITIONS indicating a possible life-threatening infection (called sepsis) requiring immediate notification of the nurse: Two or more of the following criteria in a patient with an existing infection: • Body temperature over 38 or under 36 degrees Celsius • Heart rate greater than 90 beats/minute • Respiratory rate greater than 20

1. Office of Infectious Disease and HIV/AIDS Policy. (n.d.). *Health care-associated infections.* U.S. Department of Health & Human Services. https://www.hhs.gov/oidp/topics/health-care-associated-infections/index.html

Other Considerations

The effectiveness of the immune system gradually decreases with age, making older adults more vulnerable to infection. Early detection of infection can be challenging in older adults because they may not have a fever, but instead develop subtle changes like new confusion or weakness that may result in a fall. The most common infections in older adults are urinary tract infections (UTI), pneumonia, influenza, and skin infections.[2]

2. Office of Infectious Disease and HIV/AIDS Policy. (n.d.). *Health care-associated infections*. U.S. Department of Health & Human Services. https://www.hhs.gov/oidp/topics/health-care-associated-infections/index.html

4.8 Skills Checklist: Hand Hygiene With Soap and Water

1. Gather/Ensure Adequate Supplies: Soap and paper towels
2. Procedure Steps:

    - Remove jewelry according to agency policy; push your sleeves above your wrists.
    - Turn on the water and adjust the flow so that the water is warm. Wet your hands thoroughly, keeping your hands and forearms lower than your elbows. Avoid splashing water on your uniform.
    - Apply a palm-sized amount of hand soap.
    - Perform hand hygiene using plenty of lather and friction for at least 15 seconds:
        - Rub hands palm to palm
        - Rub back of right and left hand (fingers interlaced)
        - Rub palm to palm with fingers interlaced
        - Perform rotational rubbing of left and right thumbs
        - Rub your fingertips against the palm of your opposite hand
        - Rub wrists
        - Repeat sequence at least two times
        - Keep fingertips pointing downward throughout
    - Clean under your fingernails with disposable nail cleaner (if applicable).
    - Wash for a minimum of 20 seconds.
    - Keep your hands and forearms lower than your elbows during the entire washing.
    - Rinse your hands with water, keeping your fingertips pointing down so water runs off your fingertips. Do not shake water from your hands.
    - Do not lean against the sink or touch the inside of the sink during the hand-washing process.
    - Dry your hands thoroughly from your fingers to wrists with a paper towel or air dryer.
    - Dispose of the paper towel(s).
    - Use a new paper towel to turn off the water.

- Dispose of the paper towel.

View a YouTube video[1] of an instructor demonstrating hand hygiene with soap and water:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nurseassist/?p=410#oembed-1

1. Chippewa Valley Technical College. (2022, December 3). Hand Hygiene With Soap and Water. [Video]. YouTube. Video licensed under CC BY 4.0. https://youtu.be/w29Ad7Cmsxo

4.9 Skills Checklist: Hand Hygiene With Alcohol-Based Hand Sanitizer

1. Gather Supplies: Antiseptic hand rub
2. Procedure Steps:

    - Remove jewelry according to agency policy; push your sleeves above your wrists.
    - Apply enough product into the palm of one hand and enough to cover your hands thoroughly per product directions.
    - Rub your hands together, covering all surfaces of your hands and fingers with antiseptic until the alcohol is dry (a minimum of 30 seconds):
        - Rub hands palm to palm
        - Rub back of right and left hand (fingers interlaced)
        - Rub palm to palm with fingers interlaced
        - Perform rotational rubbing of left and right thumbs
        - Rub your fingertips against the palm of your opposite hand
        - Rub your wrists
    - Repeat hand sanitizing sequence a minimum of two times.
    - Repeat hand sanitizing sequence until the product is dry.

View a YouTube video[1] of an instructor demonstrating hand hygiene with alcohol-based hand sanitizer:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nurseassist/?p=412#oembed-1

1. Chippewa Valley Technical College. (2022, December 3). Hand Hygiene With Alcohol-Based Hand Sanitizer. [Video]. YouTube. Video licensed under CC BY 4.0. https://youtu.be/rTuO8SYYfNo

4.10 Skills Checklist: Removing Gloves

1. Procedure Steps:

    - Using either hand, grasp the glove at the palm of the other hand.
    - Remove the glove.
    - Grasp the empty glove within the palm of the gloved hand.
    - Using the index and middle fingers of the bare hand, slide fingers underneath the remaining glove at the wrist.
    - Turn the remaining glove inside out while containing the first glove inside.
    - Discard in an appropriate receptacle.
    - Perform hand hygiene.

View a YouTube video[1] of an instructor demonstrating removing gloves:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nurseassist/?p=414#oembed-1

Figure 4.17[2] Glove Removal

1. Chippewa Valley Technical College. (2022, December 3). Removing Gloves. [Video]. YouTube. Video licensed under CC BY 4.0. https://youtu.be/nYDB6b3K-MY
2. "Ch.5-Taking-off-PPE-–-Step-8," Ch.5-Taking-off-PPE-Step-1a-.png," "Ch.5-Taking-off-PPE-Step-1c.png," "Ch.5-Taking-off-PPE-Step-1d," "Ch.5-Taking-off-PPE-Step-1e.png," and "Ch.5-Taking-off-PPE-Step-2.png" by unknown author are licensed under CC BY-NC 4.0. Access for free at https://ecampusontario.pressbooks.pub/introductiontoipcp/chapter/putting-it-all-together-putting-on-and-taking-off-full-ppe/

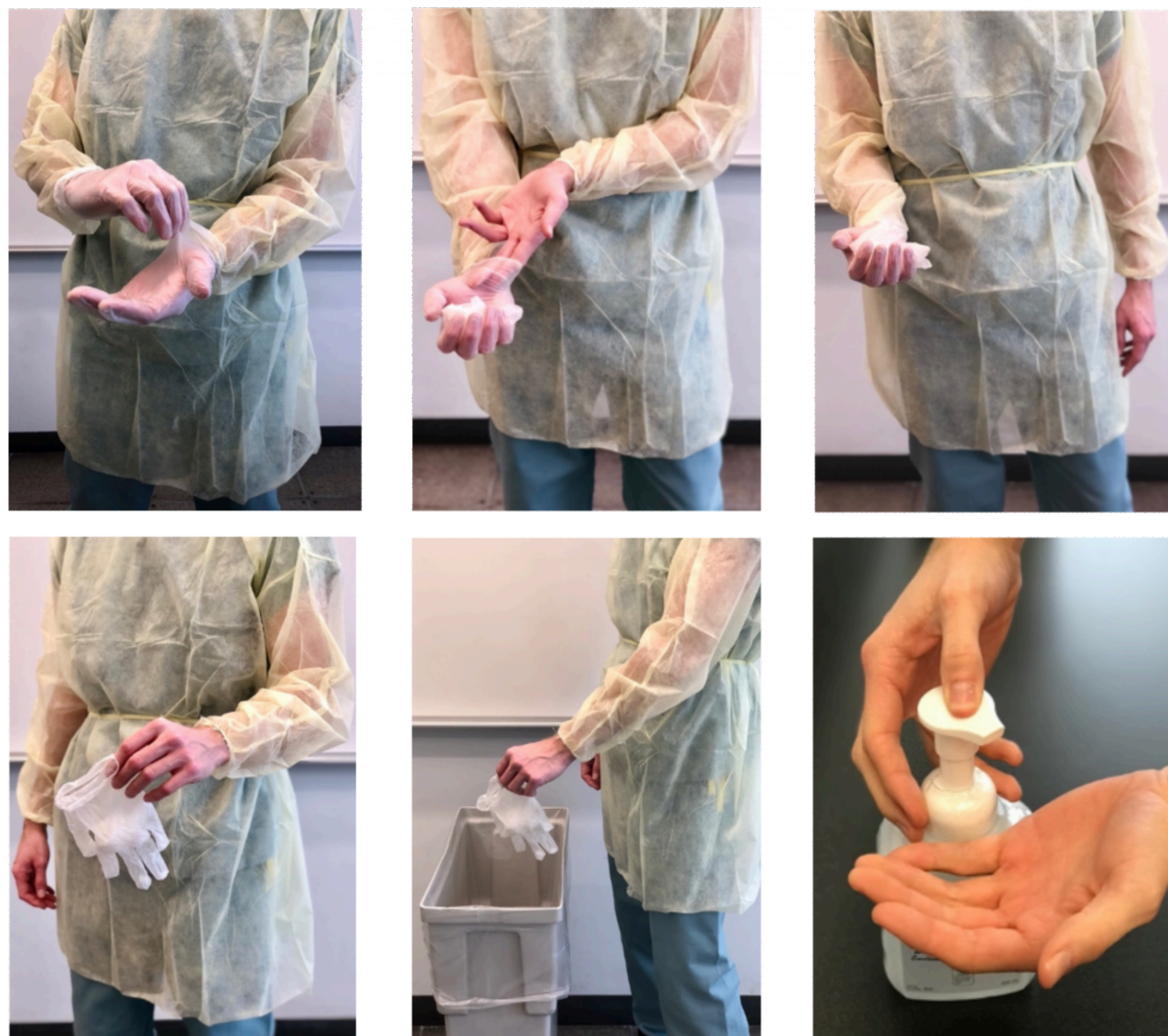


Figure 4.17 Glove Removal

4.11 Skills Checklist: Donning/Doffing PPE Without a Mask

1. Gather Supplies: Gown, gloves, and alcohol-based sanitizer
2. Procedure Steps:
    - Perform hand hygiene.
    - Face the back opening of the gown.
    - Unfold the gown.
    - Put your arms into the sleeves.
    - Secure the neck opening behind your head.
    - Secure the waist, making sure that the back flaps overlap each other and cover your clothing as completely as possible.
    - Put on gloves.
    - Ensure the gloves overlap the gown sleeves at the wrist.
    - When care has been completed and before leaving the room, remove the gloves BEFORE removing the gown.
    - Remove the gloves, turning them inside out.
    - Dispose of the gloves in the appropriate container.
    - Perform hand hygiene.
    - Unfasten the gown at the neck.
    - Unfasten the gown at the waist.
    - Remove the gown starting at the top of the shoulders, turning it inside out and folding soiled area to soiled area.
    - Dispose of the gown in an appropriate container.
    - Perform hand hygiene.

View a YouTube video[1] of an instructor demonstrating donning/doffing PPE without a mask:

1. Chippewa Valley Technical College. (2022, December 3). Donning/Doffing PPE Without a Mask. [Video]. YouTube. Video licensed under CC BY 4.0. https://youtu.be/yP1eIqGJSS8

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nurseassist/?p=418#oembed-1

4.12 Skills Checklist: Donning/Doffing PPE With a Mask and Face Shield or Goggles

1. Gather Supplies: Gown, mask, face shield, goggles, and alcohol-based sanitizer
2. Procedure Steps:
    - Face the back opening of the gown.
    - Unfold the gown.
    - Put your arms into the sleeves.
    - Secure the neck opening at the back of your neck.
    - Secure the waist, making sure that the back flaps overlap each other and covering your clothing as completely as possible.
    - Put on a mask and, if needed, goggles or face shield.
    - Put on gloves.
    - Ensure the gloves overlap the gown sleeves at the wrist.
    - When care is complete and before leaving the room, remove the gloves BEFORE removing the gown.
    - Remove the gloves, turning them inside out.
    - Dispose of the gloves in the appropriate container.
    - Perform hand hygiene.
    - Remove any goggles or face shield and place in the appropriate receptacle.
    - Unfasten the gown at the neck.
    - Unfasten the gown at the waist.
    - Remove the gown starting at the top of the shoulders, turning it inside out and folding soiled area to soiled area.
    - Dispose of the gown in an appropriate container.
    - Remove the mask by grasping loop behind ear or untying at back of head.
    - Perform hand hygiene.

Review the *Sequence for putting on personal protective equipment* PDF handout[1] from the Centers for Disease Control and Prevention (CDC) with current recommendations for putting on and removing PPE.

View a YouTube video[2] of an instructor demonstrating donning/doffing PPE with a mask and face shield or goggles:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nurseassist/?p=420#oembed-1

1. Centers for Disease Control and Prevention. (n.d.). *Sequence for putting on personal protective equipment* [Handout]. https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf
2. Chippewa Valley Technical College. (2022, December 3). Donning/Doffing PPE With a Mask and Face Shield or Goggles. [Video]. YouTube. Video licensed under CC BY 4.0. https://youtu.be/H-rXxFkmWBY

4.13 Learning Activities

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=422#h5p-11

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=422#h5p-17

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=422#h5p-19

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=422#h5p-71

IV Glossary

Airborne precautions: Transmission-based precautions used for clients with diagnosed or suspected pathogens spread by very small airborne particles from nasal and oral secretions that can float long distances through the air, such as measles and tuberculosis.

Blood-borne pathogens: Infectious microorganisms in blood and body fluids that can cause disease, including hepatitis B (HBV), hepatitis C (HCV), and human immunodeficiency virus (HIV).

Carrier: An individual who is colonized with an infectious agent.

Chain of infection: The process of how an infection spreads based on six links of transmission: Infectious Agent, Reservoir, Portal of Exit, Modes of Transmission, Portal of Entry, and Susceptible Host.

Colonization: A condition when a person carries an infectious agent but is not symptomatic or ill.

Contact precautions: Transmission-based precautions used for clients with known or suspected infections transmitted by touch such as *C-difficile* (C-diff), *methicillin-resistant staphylococcus aureus* (MRSA), *vancomycin resistant enterococcus* (VRE), or *norovirus*.

Disinfection: The removal of microorganisms. However, disinfection does not destroy all spores and viruses.

Doff: Take off personal protective equipment (PPE).

Don: Put on personal protective equipment (PPE).

Droplet precautions: Transmission-based precautions used for clients with a diagnosed or suspected pathogen that is spread in small droplets from sneezing or in oral and nasal secretions, such as influenza or pertussis.

Eye protection: Face shields, visors attached to masks, and goggles that are used to protect the eyes from blood or body fluids.

Fever: A temperature of 38 degrees Celsius (100.4 degrees F).

Hand hygiene: The process of removing, killing, or destroying microorganisms or visible contaminants from the hands. There are two hand-hygiene techniques: handwashing with soap and water and the use of alcohol-based hand rub (ABHR).

Healthcare-associated infection (HAI): An infection that develops in an individual after admission to a health care facility or undergoing a medical procedure.

Infection control: Methods to prevent or stop the spread of infections in health care settings.

Infectious agent: Microorganisms, such as bacteria, viruses, fungi, or parasites that can cause infectious disease.

Inflammation: Redness, warmth, swelling, and tenderness associated with early signs of infection.

Isolation gowns: Protective garments worn to protect clothing from the splashing or spraying of body fluids and reduce the transmission of microorganisms.

Malaise: A feeling of discomfort, illness, or lack of well-being that is often associated with infection.

Masks: Protective coverings worn by health care providers to protect the mucous membranes of their nose and mouth.

Medical asepsis: Techniques used to prevent the transfer of microorganisms from one person or object to another but do not completely eliminate microorganisms.

Mode of transmission: The way an infectious agent travels to other people and places.

Moments of hand hygiene: Appropriate times during patient care to perform

hand hygiene, including immediately before touching a patient; before performing an aseptic task; before moving from a soiled body site to a clean body site; after touching a patient or their immediate environment; after contact with blood, body fluids, or contaminated surfaces (with or without glove use); and immediately after glove removal.

Nonspecific defenses: Generic barriers that prevent pathogens from entering the body, including physical, mechanical, or chemical barriers.

PAPR: An air-purifying respirator that uses a blower to force air through filter cartridges or canisters into the breathing zone of the wearer. This process creates an air flow inside either a tight-fitting facepiece or loose-fitting hood or helmet, providing a higher level of protection against aerosolized pathogens.

Perineal care: Cleansing the genital and rectal areas of the body.

Personal protective equipment (PPE): Specialized clothing or equipment used to prevent the spread of infection, including gloves, gowns, facial protection (masks and eye protection), and respirators.

Portal of entry: The route by which an infectious agent enters a new host.

Portal of exit: The route by which an infectious agent escapes or leaves the reservoir.

Purulent drainage: Yellow, green, or brown drainage associated with signs of infection.

Reservoir: The host in which infectious agents live, grow, and multiply.

Respirator masks: Masks with N95 or higher filtration worn by health care professionals to prevent inhalation of infectious small airborne particles.

Respiratory hygiene: Methods to prevent the spread of respiratory infections, including coughing/sneezing into the inside of one's elbow or covering one's mouth/nose with a tissue when coughing and promptly disposing of used tissues. Hand hygiene should be immediately performed after contact with

one's respiratory secretions. A coughing person should also wear a surgical mask to contain secretions.

Specific defenses: Immune system processes like white blood cells attacking particular pathogens.

Standard precautions: Precautions used by health care workers during client care when contact or potential contact with blood or body fluids may occur based on the principle that all blood, body fluids (except sweat), nonintact skin, and mucous membranes may contain transmissible infectious agents. These precautions reduce the risk of exposure for the health care worker and protect patients from potential transmission of infectious organisms.

Sterilization: A process used on equipment and the environment that destroys all pathogens, including spores and viruses. Sterilization methods include steam, boiling water, dry heat, radiation, and chemicals.

Surgical asepsis: The absence of all microorganisms during any type of invasive procedure; used for equipment used during invasive procedures, as well as the environment.

Susceptible host: A person at elevated risk of developing an infection when exposed to an infectious agent.

Transmission-based precautions: Specific types of personal protective equipment (PPE) and practices used with clients with specific types of infectious agents based on the pathogen's mode of transmission.

PART V

CHAPTER 5: PROVIDE FOR PERSONAL CARE NEEDS OF CLIENTS

5.1 Introduction to Provide for Personal Care Needs of Clients

Learning Objectives

- Provide for personal grooming and hygiene
- Assist with nutrition and fluid needs
- Assist client with bowel and bladder elimination
- Maintain a urinary catheter
- Assist client with bowel and bladder retraining

Providing personal care for clients is the primary responsibility of the nursing assistant. Often referred to as Activities of Daily Living (ADLs), **personal care** includes anything that a client needs to maintain hygiene, well-being, self-esteem, and dignity. ADLs are the foundation of health and wellness and a part of providing holistic care. The manner in which personal care is provided has a large impact on the quality of life for those unable to care for themselves. A professional nursing assistant provides these services proficiently while also respecting the preferences of residents.

5.2 Activities of Daily Living (ADLs)

The main function of a nursing assistant is to provide assistance to clients with activities of daily living. **Activities of daily living (ADLs)** include hygiene, grooming, dressing, fluid and nutritional intake, mobility, and elimination needs. See Figure 5.1[1] for an illustration of ADLs. **Hygiene** refers to keeping the body clean and reducing pathogens by performing tasks such as bathing and oral care. **Grooming** also keeps the body clean but refers to maintaining a resident's appearance through shaving, hair, and nail care.

Figure 5.1 Activities of Daily Living

Specific ADLs are provided based on the time of day and the needs of the resident. Personal care performed in the morning is referred to as **A.M. care**, and personal care performed in the evening is referred to as **P.M. care**. Full baths or showers may be provided with either A.M. or P.M. care, depending on resident preferences, but a partial bath should be provided each morning.

A.M. care includes tasks such as the following activities:

- Toileting, changing incontinence brief (if used), and providing perineal care

1. "ADL-1024x534.jpg" by unknown is licensed under CC BY-SA 4.0. Access for free at https://ecampusontario.pressbooks.pub/healthassessment/chapter/functional-health

- Performing oral and/or denture care (before or after breakfast based on resident's preference)
- Assisting with a partial bath, full bath, or shower depending on the resident's personal schedule
- Changing the client's hospital gown or assisting with dressing
- Assisting with grooming, such as shaving or hair care, and applying makeup, accessories, or jewelry per resident preference
- Assisting with eating breakfast
- Providing hand hygiene to the resident as needed
- Assisting with attending activities, physical therapy (PT), and occupational therapy (OT)
- Making the bed and tidying the resident's room

P.M. care includes tasks such as the following activities:

- Toileting
- Assisting with lunch and dinner
- Assisting with a partial bath, full bath, or shower depending on the resident's personal schedule
- Assisting with oral and denture care before bed
- Helping with oral care after meals if resident prefers
- Washing face and removing makeup if worn
- Changing into gown or pajamas
- Providing hand hygiene to resident as needed
- Tidying the resident's room

5.3 Person-Centered Care

Person-centered care is a care approach that considers the whole person, not just their physical and medical needs. It also refers to a person's autonomy to make decisions about their care, as well as participate in their own care. This approach improves health outcomes of individuals and their families as care is provided according to the resident's preferences, choices, and habits held before they required assistance to care for themselves.[1]

The term "person" acknowledges a human being has rights, especially in relation to decisions and choices as previously discussed in Chapter 2. It also recognizes that a person is a human being who is made of several human dimensions. These dimensions include intellectual, environmental, spiritual, sociocultural, emotional, and physical, all of which operate together to form the whole person. In providing person-centered care, health care professionals consider all these elements while meeting health care needs.[2]

A nurse aide can focus on an individual's personhood by spending time communicating with them and finding out what interests them, what is important to them, what concerns them, and what causes them to feel unsafe. It also includes asking each person how they would like to be addressed, as well as avoiding demeaning terms like "honey," "sweetie," or "sweetheart." Promote their dignity by using age-appropriate words and avoiding words like "diaper," "bib," "potty," or "feeders." The vital element of person-centered care is effective communication between the health care provider, the client, and the client's family members or significant others. Effective communication facilitates information sharing and trust.[3]

When a nursing assistant helps clients with their ADLs, person-centered care means learning clients' personal preferences and routines. Examples of using

1. This work is a derivative of Opening Eyes onto Inclusion and Diversity by Carter (Ed.) and is licensed under CC BY-NC 4.0
2. This work is a derivative of Opening Eyes onto Inclusion and Diversity by Carter (Ed.) and is licensed under CC BY-NC 4.0
3. This work is a derivative of Opening Eyes onto Inclusion and Diversity by Carter (Ed.) and is licensed under CC BY-NC 4.0

the person-centered care approach are knowing the time the resident prefers to wake up and go to bed; their preference for showers, tubs, or bed baths; their preferred arrangement of their belongings; and their mobility issues. Cares are individualized based on these preferences. Respecting residents' dignity and privacy is demonstrated by keeping them covered and warm when bathing, explaining procedures prior to doing them, and protecting their health information. It also means respecting personal beliefs, being aware of cultural differences, and offering choices and options when available.

It is important to remember that it is often difficult for clients to feel dependent on others to provide their personal care. Nursing assistants must demonstrate empathy with clients, especially with those who are experiencing the loss of their independence. Caregivers should allow residents to do as much as possible for themselves, under appropriate supervision, while providing assistance as needed. Allow them to make decisions about their care and encourage them to perform as much self-care as possible to promote their independence, self-esteem, and sense of control over their care. An added physical benefit of encouraging residents to perform self-care is it maintains their strength and mobility, thereby preventing a decline in physical function for as long as possible.

5.4 Pre- and Post-Procedural Steps

Each time a nursing assistant provides personal cares, there are routine steps that should be performed before and after the interaction, regardless of the skills provided. Having a list of routine steps ensures the following:

- Important aspects of care won't be overlooked.
- Dignity for the client and respect for their preferences are provided.
- Risk for transmission of pathogens is reduced.
- Safety is provided.
- Necessary equipment and supplies are present.

Before providing care to a resident, follow the **SKWIPE** acronym:

- **S**upplies: Many supplies are kept in the resident's room, but ask yourself if anything is needed that is not available in the room. Being prepared prevents disruption of the procedure and possible delays that can result in discomfort for the resident.
- **K**nock: Always knock before entering a room, even if the door is open. Knocking maintains dignity for the client and shows respect for their privacy.
- **W**ash: Always perform hand hygiene when entering the resident's room to reduce the risk of transmitting pathogens from other residents, equipment, or environmental surfaces.
- **I**ntroduce and Identify: Introduce yourself to the resident with your name and your title or position at the facility. Identify the client following facility policy. For example, properly identifying a client in a hospital setting may include asking them their name and date or birth and checking their medical ID band. However, in a long-term care setting, some residents may have cognitive or sensory deficits and may not correctly state their own name, so asking their name is not always a safe manner to identify them. Instead, identification in long-term care settings is typically performed by using a photograph in the medical record or by asking another experienced staff member to confirm identification.
- **P**rivacy: Provide privacy by closing the door and pulling the privacy

curtain to ensure dignity when providing personal care.
- **E**xplain: Explain what care you will be providing so the resident can ask questions or decline care if it is not desired at that time.

After providing care to a resident, but before leaving the room, follow the **CLOWD** acronym:

- **C**omfort: Ask if the resident is comfortable and if they need anything else such as tissues, water, TV remote, etc.
- **L**ight, Lock, and Low: Place the resident's call light within reach so they can call for staff when they need assistance. Check the brakes on the bed to ensure they are locked, and the bed won't move. Place the bed in the lowest position. These and other measures such as ensuring bed and/or chair alarms are in place and turned on are vital for ensuring patient safety. If a resident decides to self-transfer out of bed instead of requesting assistance, locking and lowering the bed will reduce the risk of injury because it is lower to the floor and won't move suddenly out from underneath them.
- **O**pen: Open the door and privacy curtain. For safety reasons, residents must be within staff eyesight when they are alone in their rooms, unless they are physically able to move independently.
- **W**ash: Perform hand hygiene before leaving the room to reduce the risk of transmitting pathogens to another resident, equipment, or environmental surfaces.
- **D**ocument: Ask yourself if you provided any cares that should be documented in the medical record or if you need to report anything to the nurse or other staff member. **Routine cares** (i.e., those cares provided to every resident every day) are not necessarily documented unless they are declined or something out of the ordinary occurred or was observed. Follow agency policy regarding documentation.

5.5 Skin Care

Skin is made up of three layers: epidermis, dermis, and hypodermis. See Figure 5.2[1] for an illustration of skin layers. The epidermis is the thin, topmost layer of the skin. It contains sweat gland duct openings and the visible part of hair known as the hair shaft. Underneath the epidermis lies the dermis where many essential components of skin function are located. The dermis contains hair follicles (the roots of hair shafts), sebaceous oil glands, blood vessels, endocrine sweat glands, and nerve endings. The bottommost layer of skin is the hypodermis (also referred to as the subcutaneous layer). It mostly consists of adipose tissue (fat), along with some blood vessels and nerve endings. Beneath the hypodermis layer lie bone, muscle, ligaments, and tendons.[2]

1. "501 Structure of the skin.jpg" by OpenStax is licensed under CC BY 3.0. Access for free at https://openstax.org/books/anatomy-and-physiology/pages/5-1-layers-of-the-skin
2. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0

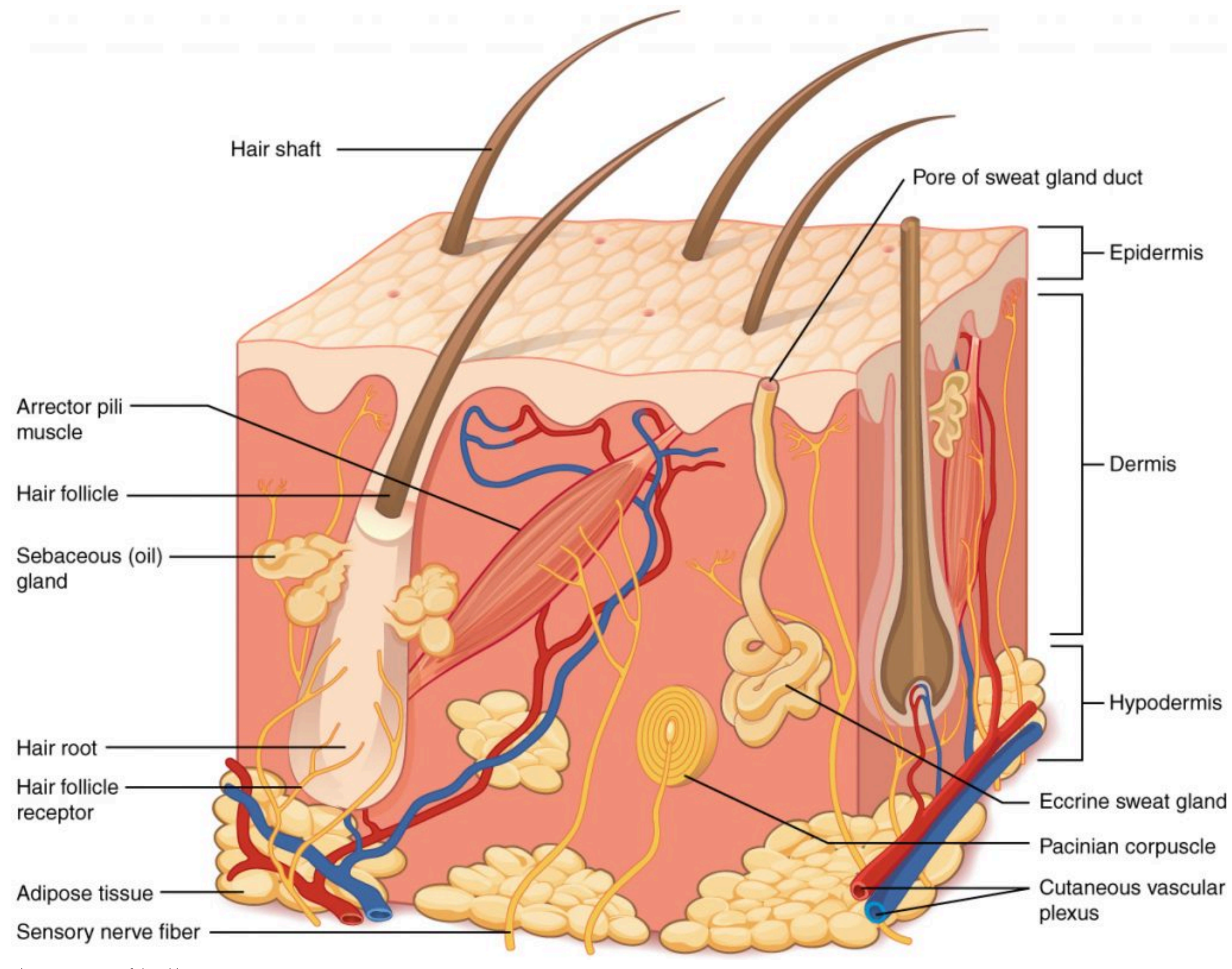


Figure 5.2 Layers of the Skin

As discussed in Chapter 4, the skin is the body's first layer of defense against pathogens entering the body. Maintaining healthy skin is an integral responsibility of the nursing assistant. Nursing assistants provide the vast majority of bathing and are able to observe and report any changes to skin integrity while performing ADLs on a daily basis. **Impaired skin integrity** refers to skin that is damaged or not healing normally. An example of impaired skin integrity is a pressure injury (also called a bedsore or pressure ulcer) with damage to the skin and surrounding tissue. See Figure 5.3[3] for an image of a pressure injury on a client's lower back above their buttocks.

3. "Decubitus 01.jpg" by AfroBrazilian is licensed under CC BY-SA 3.0

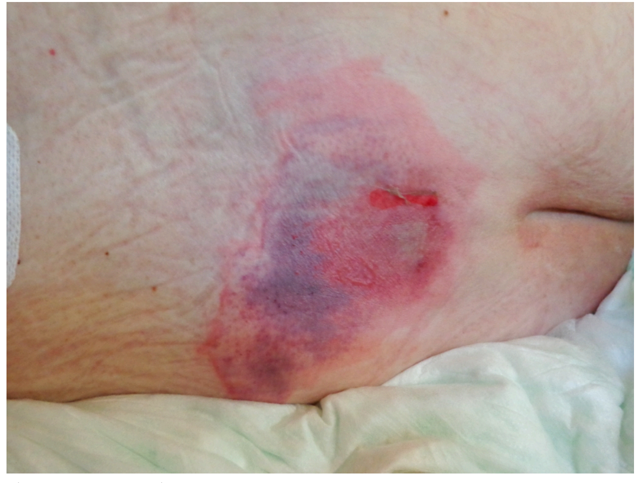


Figure 5.3 Pressure Injury

Age-Related Changes in the Skin

Several changes occur in the skin as one ages. As people age, the amount of adipose tissue decreases. Adipose tissue (i.e., body fat) provides insulation to keep one warm, as well as protection against injury by cushioning underlying structures. See Figure 5.4[4] for an image of age-related changes in the skin on the hand of an older adult.

Figure 5.4 Age-Related Changes in Skin

Oil glands are less productive, making skin drier and more susceptible to

4. “hands-578918_1280.jpg” by Gaertringen on Pixabay.com is licensed under CC0

cracking. Dry skin and cracked skin make older adults more susceptible to injuries, like skin tears and pressure injuries, that create openings for pathogens and increase the risk of infection. NAs can encourage good nutrition and hydration to help maintain good skin integrity.

Older residents also have reduced production of sweat, which affects the ability of their body to regulate their temperature. This makes them more susceptible to heat-related illness such as exhaustion and heat stroke, especially when being physically active in the heat.[5]

Skin Care Needs of Older Adults

Due to less oil and sweat production as one ages, daily showering or full body bathing is not necessary and can even be damaging to skin. Additionally, residents in long-term care settings don't typically venture out into the community regularly, thus reducing their exposure to pathogens. Due to these factors, daily partial baths are provided to maintain hygiene, but full body bathing is typically performed only weekly.

It is important to adequately dry skin folds and moisturize the skin regularly to maintain skin integrity and prevent dryness, cracking, and infection. Additionally, clients who are immobile should be repositioned at least every two hours to reduce the risk of pressure injuries. Repositioning techniques can be found in Chapter 8.

Chronic Conditions Affecting Skin Integrity

Skin needs oxygen and nutrients carried in blood to stay healthy. Any condition that impairs blood flow will increase the risk of skin conditions. As a person ages, a general decline in cardiac function decreases blood flow and oxygen to the skin, putting all older adults at increased risk for skin breakdown. Common medical disorders affecting skin health include high

5. Balmain, B. N., Sabapathy, S., Louis, M., & Morris, N. R. (2018). Aging and thermoregulatory control: The clinical implications of exercising under heat stress in older individuals. *BioMed Research International, 2018,* 8306154. https://doi.org/10.1155/2018/8306154

cholesterol that causes blockages of blood flow in the arteries, heart failure, high blood pressure, and diabetes.

Clients with diabetes are prone to developing wounds on their feet that can quickly become infected and require amputation. See Figure 5.5[6] for an image of wounds on the foot of a client with diabetes. Nursing assistants should carefully observe the client's feet and in between their toes daily and report any concerns to the nurse to preserve skin integrity. Nail care for diabetics should be performed by the Registered Nurse (RN) due to the increased risk of infection.

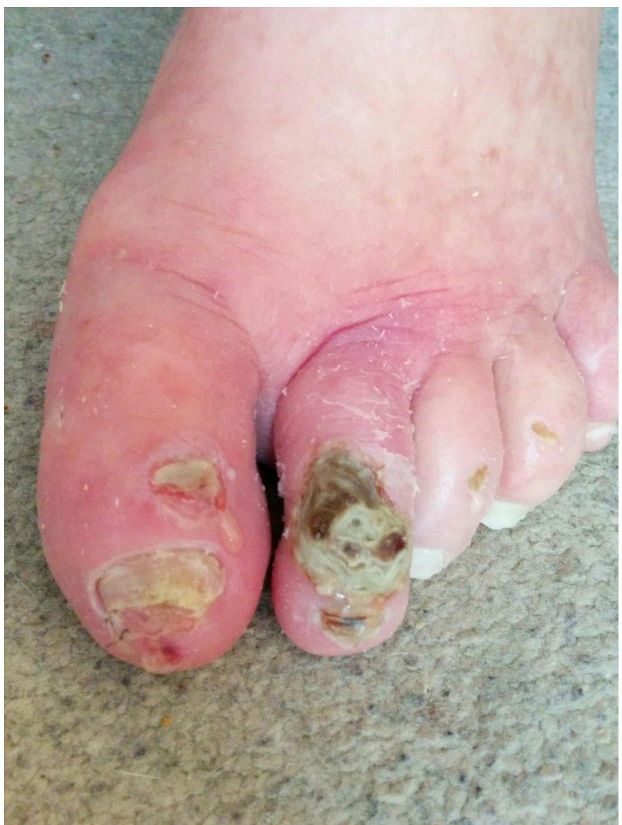


Figure 5.5 Wounds on the Foot of a Client With Diabetes

Skin care is important for all clients, but additional moisturizing and frequent repositioning should be performed for clients with increased risk for skin

6. "Two_ischaemic_ulcers_on_the_foot_of_an_individual_with_type_2_diabetes.jpg" by Bondegezou is licensed under CC BY-SA 4.0

breakdown. See Chapter 8 and 11 for more specific information on risks for skin breakdown and maintaining skin integrity.

5.6 Types of Baths and Techniques

There are four basic types of baths that are provided based on the needs, preferences, and mobility of clients: a partial bath, shower, tub bath, or full bed bath.

A **partial bath** includes washing the face, underarms, arms, hands, and **perineal** (genital and anal) area. Partial baths are given daily to maintain hygiene. They preserve skin integrity by not drying out skin with excessive soap and water use. A shower is provided for those who can safely sit in a shower chair or stand with supervision in the shower. See Figure 5.6[1] for an image of a shower chair with a transfer bench. A tub bath can be performed in a regular tub or whirlpool. A tub bath may be used for a fully independent resident or if there is a provider order for a bath treatment such as Epsom salts or oatmeal. A **complete bed bath** is a bath provided for clients who have difficulty getting out of bed, are experiencing excessive pain, or have other physical or cognitive issues that make other types of bathing less tolerable.

Figure 5.6 Shower Chair With Transfer Bench

1. "Transfer_bench.jpg" by Roger Mommaerts is licensed under CC BY-SA 2.0

A resident has the right to choose any type of bath as long as it is safe to do so. A whirlpool bath can be relaxing and enjoyable for any resident, whereas a bed bath can maintain warmth while keeping the majority of the body covered.

If a resident is hesitant about bathing, different types of baths should be offered based on their preference. It is also possible to delay a scheduled bath to a different time of day or an alternate day, as long as their hygiene needs are being met. If a resident continues to be resistant to bathing, different approaches should be attempted until the person is comfortable and hygiene is maintained. Keep in mind that resistance to bathing can be common during the aging process, especially in clients with dementia as the disease progresses.

- Visit the following site to read additional bathing techniques and products for unique situations: Bathing Without a Battle.

Considerations During Bathing

Nursing assistants should maintain privacy and comfort for those receiving assistance with bathing. Residents can become uncomfortable due to many factors during bathing. For example, if they require transportation to the shower area in the hallway on a shower chair, the chair can be uncomfortable or cold, or they may be concerned about being exposed. Bath blankets should be placed over the resident, paying attention to tucking the blanket behind the resident's back and underneath their legs to keep any skin from showing. Residents should also wear shoes or socks to prevent any skin injuries to feet. A towel over the top of their head can assist in keeping them warm, and the shower chair can be padded around the seat with towels or washcloths. Often the seat back is made of mesh to aid in water drainage, which can be covered with a towel to prevent irritation to the resident's back and shoulders. If the resident's feet don't reach the support bar of the chair, a wash basin can be

turned upside down and placed under their feet to give them a more secure feeling during transport. There is an increased risk for patient falls during bathing, and NAs must take appropriate measures to prevent falls due to unsteadiness or wet floors or equipment.

During the bath, the aide should work from head to toe to prevent spreading pathogens from the perineal area to other parts of the body. Start with the face and neck, then proceed to the front and back of the upper body, then the front and back of the legs, and finish with the perineal area. The aide must ensure gloves are changed and hand hygiene is performed immediately after performing perineal care. See Skills Checklists 5.18 and 5.19 regarding performing perineal care for more information.

Because much of the body's heat is lost through the head, it may be preferable to wash the resident's hair last. Provide the resident with a dry washcloth or towel to cover their face and prevent shampoo from getting in their eyes. Gently tipping the head back will keep the majority of the water from falling onto their face.

When assisting a client with bathing, there are several things to observe, consider, and report to the nurse:

- Report any open or reddened areas; dry, flaky skin; bruises; rashes; or irritation. Check all areas of the skin, especially where moisture can be trapped, such as underneath breasts, in abdominal and groin folds, in armpits, and between the toes. If a client has an existing wound or skin breakdown, the nurse should be notified prior to the bath so that an assessment can be completed.
- Report any foul odors that remain after bathing.
- Report subjective or objective signs of pain. For example, the client may pull away when a painful area on their body is touched with a washcloth.
- Report changes in behavior, such as withdrawal or agitation during bathing.
- Report any discharge from any mucous membranes.

See Skills Checklists 5.9-5.13 for performing specific steps for each type of bath and shampooing a client’s hair.

5.7 Assisting With Nutrition and Fluid Needs

Mealtime should be as enjoyable as possible, especially for those clients requiring assistance. As with any other aspect of providing personal care, nursing assistants should use empathy. Think about what it would feel like if you had cognitive or sensory deficits and could not ask for what you want to eat even though it is on the plate in front of you. Recognize how the presentation of the food and the table influence one's appetite. Consider with whom you like to share your meal. All these factors should be considered when feeding a resident.

Avoid using feeding techniques that are used with young children, such as making noises, moving utensils like airplanes, etc. Residents should be offered a clothing protector to avoid soiling their clothes or gown, but to maintain their dignity, these protectors should never be referred to as a "bib."

When the meal is ready to consume, describe to the resident what they have on their tray to eat and drink. If the client is visually impaired, use the **clock method** to describe their plate so they know where each food is located. For example, the nursing assistant can state, "Your mashed potatoes are at 10 o'clock, the green beans are at 2 o'clock, and the meat loaf is at 6 o'clock on your plate." If a resident has an order for a **pureed diet** (i.e., all food is blended to smooth consistency), know what each food is and name it when assisting the resident.

Nutritional requirements for each resident are determined by the dietary staff. Each resident has a specific type of diet ordered, including texture and consistency of liquids. It is imperative for nursing assistants to check the resident's care plan to know what type of diet is currently ordered and be familiar with the appearance of these types of diets. These steps ensure the correct foods and fluids are provided to residents and reduces the risk of choking and aspiration. **Aspiration** refers to inadvertently breathing fluid or food into the airway instead of swallowing it. Diets are further discussed in Chapter 6. See the "Preparing Clients for Meals and Assisting With Feeding" checklist for specific steps when assisting clients with feeding.

Things to observe for and report during feeding include the following:

- Coughing or frequent clearing of the throat while eating. This may be a sign of aspiration.
- A **wet voice**, meaning vocalization with sounds as if food or fluids remain in the mouth or throat.
- Difficulty swallowing.
- Pain with chewing or swallowing.
- Broken or cracked teeth or dentures that don't fit properly.
- Changes in appetite.

Thinking back to Maslow's Hierarchy, physiological needs such as food and fluids are the basis of a healthy existence. Digestive, circulatory, and urinary system changes related to aging will be discussed further in Chapter 11, but aging can pose several risk factors to nutritional and fluid intake. Poor dentition can cause changes in food choices. Someone with missing, cracked, or painful teeth, ill-fitting dentures, or other oral concerns may choose softer foods. A declining sense of smell, taste, or vision can decrease appetite. Pain with movement or other factors that limit mobility may make elimination difficult, which may be a factor in decreasing intake, so toileting needs are less frequent. These are just a few of the aging issues that can lead to malnutrition, dehydration, or both in aging clients and those unable to care for themselves.

Feeding Aids

There are several assistive devices that allow residents to more easily feed themselves.

Built-up handles allow the use of utensils by individuals with limited functional ability of their fingers to hold a smaller handle (such as for someone with severe arthritis). Silverware with prebuilt handles can be purchased, or a foam tube can be placed around regular silverware and removed for washing.

Weighted silverware has a weighted handle for individuals with tremors or

unsteady hands. The weight slows down the shaking and allows food to remain on the utensil. See Figure 5.7[1] for an image of built-up handles and weighted silverware.

Figure 5.7 Built-Up and Weighted Silverware

Swivel spoons rotate so if the resident's hand shakes, the spoon doesn't move, and the food remains on the utensil. See an image of a swivel spoon in Figure 5.8.[2]

Figure 5.8 Swivel Spoon

Covered cups prevent liquids from spilling due to tremors and also slow

1. "Built-Up-Silverware-scaled.jpg" by Myra Reuter for Chippewa Valley Technical College is licensed under CC BY 4.0
2. "Swivel-Spoon-scaled.jpg" by Myra Reuter for Chippewa Valley Technical College is licensed under CC BY 4.0

down the rate of fluid leaving the cup. For example, individuals with aspiration risk (as discussed in Chapter 6.2, "Nutrition and Fluid Needs") may be permitted to drink regular liquids out of a covered cup rather than requiring thickened liquids. See an image of a covered cup in Figure 5.9.[3]

Figure 5.9 Covered Cup

Nosey cups are used for clients with limited neck mobility. The nosey cup allows them to drink all of the fluid in the cup without tipping their head back. The cut-out portion of the cup fits around the person's nose so it can be tilted up to finish the fluid. See an image of a nosey cup in Figure 5.10.[4]

Figure 5.10 Nosey Cup

3. "Kennedy-Cup-scaled.jpg" by Myra Reuter for Chippewa Valley Technical College is licensed under CC BY 4.0
4. "Nosey-Cup-scaled.jpg" by Myra Reuter for Chippewa Valley Technical College is licensed under CC BY 4.0

Plate guards are used for individuals who can use only one hand or who have difficulty maneuvering utensils. Food can be pushed onto the utensil by pushing it against the plate guard. The plate guard can be placed on any plate (such as the image of the plate in Figure 5.11[5]), or it may be on a special plate made with the guard built on the plate surface (as in Figure 5.12[6]).

Figure 5.11 Plate Guard

Figure 5.12 Built-Up Plate

5. "Plate-Guard-scaled.jpg" by Myra Reuter for Chippewa Valley Technical College is licensed under CC BY 4.0
6. "Built-Up-Plate-scaled.jpg" by Myra Reuter for Chippewa Valley Technical College is licensed under CC BY 4.0

Documentation of Food and Fluids

Documentation of food and fluids gives insight to the overall health and well-being of clients. It gives nurses, dieticians, health care providers, and other staff insight into possible health concerns. Documenting intake is an important responsibility of nurse aides. Unless otherwise indicated, food intake is documented by estimating to the nearest 25% of intake. It is also appropriate to note that a resident only ate "bites of food." See Figures 5.13 – 5.16[7] for examples of food intake.

Figure 5.13 25% intake or "bites"

Figure 5.14 50% intake

7. "25 percent intake.png," "50 percent intake.png," "75 percent intake.png," and "100 percent intake.png" by Nic Ashman for Chippewa Valley Technical College are licensed under CC BY 4.0

Figure 5.15 75% intake

Figure 5.16 100% intake

Any fluids documented in health care are converted to milliliters (mL) or cubic centimeters (cc). Milliliters and cubic centimeters are the same units, so 1 mL = 1 cc. Typically, fluids are measured in ounces in the United States, so a conversion is necessary. To do so, multiple the number of ounces by 30, as 1 ounce = 30 cc = 30 mL. Examples of fluid conversions are provided in Table 5.7.

Table 5.7 Conversions of Ounces to Milliliters (mL) or Cubic Centimeters (cc)

Fluid Ounces	Conversion	Milliliters or Cubic Centimeters
6 oz	x 30	180 mL or cc
4 oz	x 30	120 mL or cc
1 cup = 8 oz	x 30	240 mL or cc

In addition to beverages, anything that melts at room or body temperature is documented as fluids. This includes food items such as clear broth, ice chips,

ice cream, popsicles, and Jell-O. However, soup is documented as part of the client's food intake.

5.8 Assistance With Toileting

Just as there are several bathing techniques based on a resident's functioning and mobility, there are multiple methods for assisting residents with their bladder and bowel elimination. Regardless of the method used, residents should be offered toileting assistance at least every two hours. The following subsections provide an overview of each toileting method and when it may be implemented.

Toilet

The resident should be able to stand independently, walk, or pivot transfer with assistance. A mechanical lift that assists with bearing weight may also be used to place a resident on the toilet.

Bedpan

Bedpans are used for residents who cannot bear weight or prefer to stay in bed, such as when having to urinate during the night. Residents who require a full body lift to transfer typically require the use of a bedpan, but there are also toileting slings to assist a fully dependent resident to use a toilet or commode. See Figure 5.17[1] for an image of two types of bedpans. The image on the left is a standard bedpan and the image on the right is called a fracture pan. Fracture bedpans are smaller than standard bedpans and have one flat end. They are designed for individuals recovering from a hip fracture or hip replacement.

1. "Bedpan.jpg", "Fracture Bedpan.jpg", and "Fracture Bedpan View 2.jpg" by Landon Cerny are licensed under CC BY 4.0

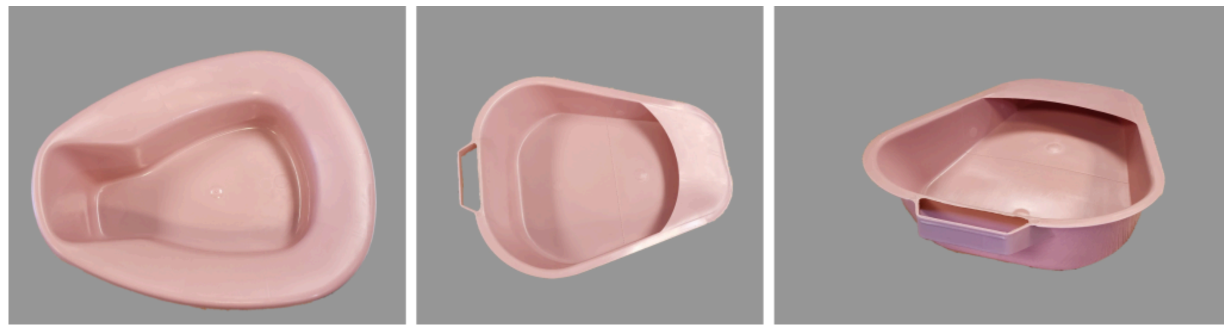


Figure 5.17 Bedpan Examples

For residents with strong hip mobility who require a bedpan, ask them to bend their knees and push their hips upwards. While they are raised, place a barrier (e.g., a towel, waterproof soaker pad, disposable pad, etc.) under them and then place a standard bedpan underneath their buttocks. Ensure the handle of the fracture pan (or the opening of the rim on a full bedpan) is pointed towards the foot of the bed before they lower themselves onto the bedpan. For residents with limited hip mobility, use their lift sheet to roll them away from you towards a raised side rail. While they are lying on their side and holding the side rail, return the lift sheet on top of the bed and then place a barrier on top of the lift sheet. Place a fracture pan behind the resident's buttocks and then gently roll both the resident and the fracture pan back to the bed surface, ensuring proper placement of the pan.

Please see Skills Checklist for additional information.

Commode

A **commode** looks like a toilet, but it is a movable device with a bucket underneath the seat. See Figure 5.18[2] for an image of a commode. Commodes are typically placed near the bed for residents who have limited weight-bearing ability, do not want to share a bathroom with another resident, or have urge incontinence. **Urge incontinence** means that as soon as the person feels the need to empty their bladder, they have very little time before urine escapes.

2. "Bedside Commode" by Landon Cerny is licensed under CC BY 4.0

Figure 5.18 Bedside Commode

Incontinence Briefs or Pads

Incontinence briefs or pads are disposable products used for residents who have little to no control over bladder or bowel function and are worn in, or in place of, their underwear. Please see Skills Checklist for additional information.

Urinary Catheter

A urinary catheter is a device placed into the bladder by a nurse using sterile technique that allows the urine to drain into a collection bag. Urinary catheters are used sparingly due to increased risk of urinary tract infections. Catheters are typically used for clients with urinary retention, have a wound near the perineal area that may become infected due to incontinence, or have a neurological condition that does not allow them to control their bladder function. See Figure 5.19[3] for an illustration of an indwelling urinary catheter attached to a collection bag. Nursing assistants may assist in emptying/documenting urine output from the collection bag or providing catheter care according to agency policy. Please see 5.25 Skills Checklist for additional information.

3. "Foley Catheter with Collection Bag and Leg Strap" by Landon Cerny is licensed under CC BY 4.0

Figure 5.19 Indwelling Urinary Catheter With a Collection Bag

Urostomy

A **urostomy** is placed surgically to collect urine from the ureters when the bladder is diseased or has been removed. Urostomies are typically located on the lower right side of the abdomen, and urine is collected into a drainage bag. See Figure 5.20[4] for an illustration of a urostomy.

4. "Diagram_showing_how_a_urostomy_is_made_(ileal_conduit)_CRUK_124.svg" by Cancer Research UK is licensed under CC BY-SA 4.0

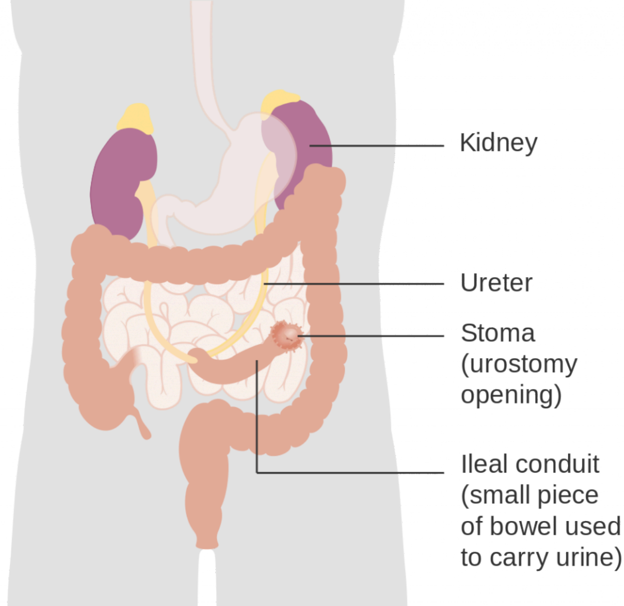


Figure 5.20 Urostomy

Colostomy

A **colostomy** is placed surgically when colon function is impaired. A piece of the colon is diverted to an artificial opening in the abdominal wall called a stoma, and feces is collected in a pouch.

Considerations When Assisting Clients With Toileting

Nursing assistants must consider a resident's privacy and dignity when assisting with toileting just as they do with bathing. Most residents prefer to be alone when urinating or defecating. Privacy can be provided by closing the bathroom door if the resident is able to be left alone. If the resident is not safe to be left alone, close the door as much as possible while keeping the resident within eyesight. Maintain awareness of a resident who is toileting or on the bedpan so they do not need to wait for assistance with perineal care after elimination and will not develop any skin issues from sitting on a hard surface.

To maintain dignity, nurse aides should be careful when explaining and providing care related to toileting. For example, a disposable brief should never be referred to as a diaper; acceptable terms include a brief, pad, liner, or disposable underwear. Additionally, a nurse aide should never show

reluctance or appear burdened when providing toileting assistance, no matter how often a resident feels the need to be toileted or requires perineal care due to incontinence.

Bladder and Bowel Retraining

Clients who are dependent on others for assistance with elimination should be taken to the bathroom or offered toileting options every two hours. Incontinence is a very personal matter and can be embarrassing for clients. Nursing assistants should use therapeutic communication when assisting clients with toileting.

When indicated, clients may undergo bladder and bowel retraining to regain control of elimination. There are several strategies used to promote bladder continence. The nurse aide may assist the nurse with one of the strategies called timed voiding. **Timed voiding** encourages the patient to urinate on a set schedule, such as every hour, whether they feel the urge to urinate or not. The time between bathroom trips is gradually extended with the general goal of achieving four hours between voiding. Timed voiding helps to control urge and overflow incontinence as the brain is trained to be less sensitive to the sensation of the bladder walls expanding as they fill.[5]

Bowel retraining involves teaching the body to have a bowel movement at a certain time of the day. This training includes encouraging clients to go to the bathroom when feeling the urge to do so and not ignoring the urge. For some individuals, it is helpful to schedule this consistent time in the morning when the natural urge occurs after drinking warm fluids or eating breakfast. For other people, especially those with a neurological cause, a laxative may be scheduled regularly to stimulate the urge to have a bowel movement on a regular basis and prevent constipation. The nurse should communicate to the

5. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0

nursing assistant when bowel retraining is in place, or a laxative is administered to a client so they are aware of the client's need to defecate.[6]

Urinary Tract Infection (UTI)[7]

A **urinary tract infection (UTI)** is a common infection that occurs when bacteria, typically from the rectum, enter the urethra and infect the bladder or kidneys. Infections can affect several parts of the urinary tract, but the most common type is a bladder infection. Kidney infections are more serious than a bladder infection because they can have long-lasting effects on the kidneys.

Some people are at higher risk of getting a UTI. UTIs are more common in females because their urethras are shorter and closer to the rectum, which makes it easier for bacteria to enter the urinary tract. Providing improper perineal care is a common cause of a UTI. Nursing assistants must be diligent and assist with perineal hygiene as needed to prevent infections. Other factors that can increase the risk of UTIs include the following:

- A previous UTI
- Sexual activity, especially with a new sexual partner
- Pregnancy
- Age (Older adults and young children are at higher risk)
- Urinary retention
- Low fluid intake
- Structural problems in the urinary tract, such as prostate enlargement

Symptoms of a UTI should be reported to the nurse immediately and include the following:

- Pain or burning while urinating (dysuria)
- Frequent urination (frequency)

6. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0
7. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0

- Urgency with small amounts of urine
- Bloody urine
- Pressure or cramping in the groin or lower abdomen
- Confusion or altered mental status in older adults

Symptoms of a more serious kidney infection (called pyelonephritis) include fever above 101 degrees F (38.3 degrees C), shaking chills, lower back pain or flank pain (i.e., on the sides of the back), and nausea or vomiting.

It is important to remember that older adults with a UTI may not exhibit these common symptoms but instead demonstrate an increased level of confusion. Older adults often become weaker when they have a UTI and may fall. If you notice increased weakness or a change in the level of confusion in an older client, report these symptoms to the nurse immediately. If not treated quickly, UTIs can spread to the blood (called septicemia), leading to life-threatening infection called **sepsis**.

When a patient has symptoms related to a possible UTI, the health care provider will order diagnostic tests, such as a urine dip, urinalysis, or urine culture. See the subsection below on "Specimen Collection," which details how nursing aides assist with these tests. Antibiotics are prescribed for urinary tract infections and are administered by the nurse. Nursing assistants should encourage clients with UTIs to drink extra fluids to help flush bacteria from the urinary tract, and toileting should be offered more frequently with proper perineal care.

Observation and Documentation of Urinary Output

When assisting residents with urinary elimination, their urine should be observed for the characteristics described in Table 5.8. Terms used to document these characteristics are included.

Characteristics of urine can be indicative of a urinary tract infection or dehydration and should be reported to the nurse. Dark urine, minimal urine output, or the infrequent need to void can be signs of dehydration. Characteristics of an infection are described in the previous "Urinary Tract

Infection (UTI)” subsection. If noted and reported promptly, fluids can be encouraged to help treat these conditions.

Table 5.8 Urine Characteristics

Characteristic	Normal Observation	Abnormal Observation	Documentation Terminology
Color	Amber (like a stoplight) or straw-colored	Dark amber or possibly root beer or cola-colored	Amber or cola
Odor	Acidic	Noticeably stronger odor than usual	Strong
Clarity	Clear	Cloudy	Cloudy
Sediment	None present	Particles present	Sediment noted
Amount	Generally 250-350 cc	More or less than usual amount	Amount in milliliters or cubic centimeters. Minimal amount may be described as scant

If a resident is regularly incontinent and uses a brief or disposable pad for elimination, the nursing assistant should document the number of times the resident is incontinent rather than recording the amount. For a continent resident, use a toilet hat to measure urine output as described in the “Specimen Collection” subsection below. If the resident uses a commode or bedpan, place a graduated cylinder on a barrier, carefully pour the urine into the graduated cylinder, and observe and document the characteristics. See Figure 5.21[8] for an image of a graduated cylinder.

8. "Graduated Cylinder" by Landon Cerny is licensed under CC BY 4.0

Figure 5.21 Graduated Cylinder

Observation and Documentation of Stool

Similar to urine, stool output and characteristics can indicate underlying health concerns. Risk factors to healthy stool elimination will be discussed further in the "Digestive System" section in Chapter 11, but slowing of the digestive system, decreased intake, and lower mobility can all contribute to constipation and even cause bowel obstruction. Documentation and reporting of unusual characteristics can assist nurses in providing interventions that can prevent more serious health concerns.

Elimination patterns vary for each individual, but a typical range for bowel elimination is twice daily to once every other day. When regular bowel movements do not occur, stool becomes hardened in the colon, making it difficult to push out, especially for those who are physically declined. Stool should be soft and formed when eliminated to prevent additional problems like hemorrhoids. Stool that is loose or liquid may indicate an infection or other chronic intestinal issues.

Nursing assistants should note the size of a client's bowel movement as "small," "medium," or "large" as an estimation. Using agency protocol, the consistency of the stool should also be documented. The Bristol Stool Chart is a common tool used to easily observe and document the consistency of stool.

See Figure 5.22[9] for an image of the Bristol Stool Chart. Additionally, if any blood or dark tarry stool is observed, this should be reported immediately to the nurse.

BRISTOL STOOL CHART

Type	Description	Indication
Type 1	Separate hard lumps	Very constipated
Type 2	Lumpy and sausage like	Slightly constipated
Type 3	A sausage shape with cracks in the surface	Normal
Type 4	Like a smooth, soft sausage or snake	Normal
Type 5	Soft blobs with clear-cut edges	Lacking fibre
Type 6	Mushy consistency with ragged edges	Inflammation
Type 7	Liquid consistency with no solid pieces	Inflammation

Figure 5.22 Bristol Stool Chart

Specimen Collection[10]

Urinary Samples

Urinary samples may need to be collected to detect infection. When needed, obtain a toilet hat (see Figure 5.23“Toilet Hat” and “Commode with Toilet Hat” by Landon Cerny are licensed under CC BY 4.0[/footnote]. Ask the nurse to label a specimen cup before collecting urine (see Figure 5.24[11]).

When assisting in collecting a urine specimen, place the cup and toilet hat on a barrier to prevent contamination with bacteria from the environment. Apply

9. “Bristol_stool_chart.svg” by Cabot Health, Bristol Stool Chart is licensed under CC BY-SA 3.0
10. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0
11. “Sterile Specimen Container" by Landon Cerny are licensed under CC BY 4.0

gloves and assist the client when needed to clean around the urethra to remove any external pathogens. If able, ask the resident to void a small amount of urine into the toilet. Place the toilet hat in the front of the toilet and instruct the resident to void into the hat. Do not put toilet paper or any other products into the toilet hat. After urination, assist the resident in completing perineal care and transferring from the toilet. Remove dirty gloves, perform hand hygiene, and apply new gloves to prevent contamination of the urine with bacteria from the perineal area. Pour the urine sample from the toilet hat into the specimen cup and tightly put on its cover. Remove gloves and perform hand hygiene before writing the time of collection on the label. Immediately bring the urine sample to the nurse.

Figure 5.23 Toilet Hat

Figure 5.24 Specimen Cup

Stool Samples

Stool samples are collected from patients to test for cancer, parasites, or for occult blood (i.e., hidden blood). The Guaiac-Based Fecal Occult Blood Test (gFOBT) is a commonly used test to find hidden blood in the stool that is not visibly apparent. As a screening test for colon cancer, it is typically obtained by the patient in their home using samples from three different bowel movements. Nursing assistants may collect gFOBT specimens for clients.

Before the test, the nurse should verify that the client has avoided red meat for three days and has not taken aspirin or nonsteroidal anti-inflammatory drugs (NSAIDs), such as ibuprofen, for seven days prior to the test. (Blood from the meat can cause a false positive test, and aspirin and NSAIDS can cause bleeding, also leading to a false positive result.) Vitamin C (more than 250 mg a day) from supplements, citrus fruits, or citrus juices should be avoided for 3 to 7 days before testing because it can affect the chemicals in the test and make the result negative, even if blood is present.

To perform a gFOBT in an inpatient setting, perform the following steps.

- Verify with the nurse that the client has met dietary and medication requirements.
- Explain the procedure to the client. Assist the resident to a clean, dry commode and instruct them not to put any toilet paper in the commode,

as this may alter the test result. Request they use the call light when they have had a bowel movement.

- Review the manufacturer's instructions with the nurse.
- Label the card with the patient's name and medical information per agency policy. Open the flap of the guaiac test card.
- Apply nonsterile gloves. Use the applicator stick to apply a thin smear of the stool specimen to one of the squares of filter paper on the card. Obtain a second specimen from a different part of the stool and apply it to the second square of filter paper on the card. (Occult blood isn't typically equally dispersed throughout the stool.)
- Place the labeled test card in a transport bag.
- Remove gloves and perform hand hygiene.
- Give the transport bag to the nurse to send to the laboratory for analysis.

5.9 Skills Checklist: Partial Bath

1. Gather Supplies: Wash basin, warm water, soap, lotion, two washcloths, one towel, barrier, gloves, clean clothes or gown, and linen bag or hamper. See Figure 5.25[1] at the end of this checklist for an image of a wash basin.
2. Routine Pre-Procedure Steps:
    - Knock on the client's door.
    - Perform hand hygiene.
    - Introduce yourself and identify the resident.
    - Maintain respectful, courteous, and professional communication at all times.
    - Provide for privacy.
    - Explain the procedure to the client.
3. Procedure Steps:
    - Put on gloves.
    - Fill the basin with warm water and place it on a flat surface with a barrier underneath. Have the resident check the water temperature by placing their hand in the basin or putting a wet washcloth on the back of their hand.
    - Raise the bed height to a working height.
    - Keep the resident covered as much as possible using a bath blanket or bed linens.
    - Wash the resident's face using water only.
    - Pat dry the face.
    - Remove the gown from one arm, keeping the rest of the body covered.
    - Place a towel under one arm, only exposing the arm.
    - Wet a washcloth, put soap on the washcloth, and wash the arm with soap.

1. "Wash Basin" by Landon Cerny is licensed under CC BY 4.0

- Wash the hand with soap.
- Wash the underarm with soap. Place the washcloth containing soap on the edge of the basin or barrier.
- Rinse the arm with the second washcloth.
- Rinse the hand.
- Rinse the underarm.
- Pat dry the arm.
- Pat dry the hand.
- Pat dry the underarm.
- Move to the other side of the bed and repeat actions on the other side of the body.
- Dispose of the gown into a linen bag or laundry hamper.
- Ask the resident if they would like lotion. When applying lotion, wear gloves.
- Assist the resident to put on a clean gown or clothes.
- While wearing gloves, empty the equipment.
- Rinse the equipment.
- Dry the basin.
- Return the equipment to storage.
- Dispose of soiled linen in the designated laundry hamper.
- Remove the gloves, turning them inside out.

4. Post-Procedure Steps:

   - Perform hand hygiene.
   - Check for resident comfort and if anything else is needed.
   - Be sure the bed is low and locked. Check the brakes.
   - Place the call light or signaling device within reach of the resident.
   - Open the door and privacy curtain.
   - Perform hand hygiene.
   - Document and report any skin issues or changes noted with the resident.

Figure 5.25 Wash Basin

View a YouTube video[2] of an instructor demonstrating a partial bath:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nurseassist/?p=284#oembed-1

2. Chippewa Valley Technical College. (2022, December 3). Partial Bath. [Video]. YouTube. Video licensed under CC BY 4.0. https://youtu.be/iR1r-_SKVpc

5.10 Skills Checklist: Full Bed Bath

1. Gather Supplies: Basin, warm water, soap, shampoo and conditioner if used, lotion, six washcloths, two towels, barrier, gloves, clean clothes or gown, and linen bag or hamper
2. Routine Pre-Procedure Steps:
    - Knock on the client's door.
    - Perform hand hygiene.
    - Introduce yourself and identify the resident.
    - Maintain respectful, courteous, and professional communication at all times.
    - Provide for privacy.
    - Explain the procedure to the client.
3. Procedure Steps:
    - Fill the basin with warm water and place it on a flat surface with a barrier underneath. Have the resident check the water temperature by placing their hand in the basin or putting a wet washcloth on the back of their hand.
    - Place a towel under one leg, keeping the rest of the body covered with the bath blanket.
    - Wash the leg with soap, only exposing the leg.
    - Wash the feet with soap.
    - Rinse the leg and feet.
    - Pat the leg and feet dry.
    - Repeat on the other leg.
    - Raise the side rail on one side of the bed.
    - Move to the opposite side of the bed and assist the resident to roll on their side using a lift sheet or other supportive device.
    - Wash the back while keeping the rest of the body covered.
    - Rinse the back.
    - Pat the back dry.
    - Dispose of the gown and used linens into the linen bag or laundry

hamper.

- Ask the resident if they would like lotion. If applying lotion, wear gloves.
- Perform perineal care using clean linens according to Chapters 5.18 & 5.19 "Perineal Care Skills Checklists."
- Assist the resident to put on a clean gown or clothes and apply an incontinence product if needed.
- While wearing gloves, empty the equipment.
- Rinse the equipment.
- Dry the basin.
- Return the equipment to storage.
- Dispose of soiled linen in the designated laundry hamper.
- Remove the gloves, turning them inside out.

4. Post-Procedure Steps:

   - Perform hand hygiene.
   - Check for resident comfort and if anything else is needed.
   - Be sure the bed is low and locked. Check the brakes.
   - Place the call light or signaling device within reach of the resident.
   - Open the door and privacy curtain.
   - Perform hand hygiene.
   - Document and report any skin issues or changes noted with the resident.

Note: Shampooing can be done before washing face, after washing back, or after perineal care per resident preference. See "Shampoo Skills Checklist" for specific steps.

View a YouTube video[1] of an instructor demonstrating a full bed bath:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nurseassist/?p=286#oembed-1

1. Chippewa Valley Technical College. (2022, December 3). Full Bed Bath . [Video]. YouTube. Video licensed under CC BY 4.0. https://youtu.be/j5GYMOvjjtk

5.11 Skills Checklist: Shower

1. Gather Supplies: Soap, shampoo and conditioner if used, lotion, two washcloths, several towels, barrier, gloves, clean clothes or gown, and linen bag or hamper
2. Routine Pre-Procedure Steps:
    - Knock on the resident's door.
    - Perform hand hygiene.
    - Maintain respectful, courteous, and professional communication at all times.
    - Introduce yourself and identify the resident.
    - Provide for privacy.
    - Explain the procedure to the resident.
3. Procedure Steps:
    - Assist the resident to the shower per facility protocol. See the "Considerations During Bathing" subsection in this chapter and implement comfort measures. Keep the resident covered as long as possible and have the resident test the water temperature on their fingers. Repeatedly check the water temperature throughout the shower.
    - Put on gloves.
    - Wet a washcloth and wash the face without soap.
    - Put soap on the washcloth and wash the resident, starting with their upper body and then their legs.
    - Lift any skin-on-skin areas and wash gently with soap.
    - Wash the front of the perineal area.
    - Reach through the bottom of the shower chair and wash the rectal area from front to back.
    - Remove the gloves, turning them inside out.
    - Perform hand hygiene.
    - Put on clean gloves.
    - Rinse the resident starting with the upper body, followed by the legs,

front perineal area, and rectal area.
  - Change the gloves and perform hand hygiene if the perineal area was touched during rinsing.
  - Turn off the water and place warm towels to cover the resident
  - Pat dry.
  - Ask the resident if they would like lotion. If applying lotion, wear gloves.
  - Assist the resident to put on a clean gown or clothes, keeping a dry towel over the back of the shower chair and avoiding getting the gown or clothes wet.
  - Place nonskid footwear on the client.
  - Assist the resident to stand per their care plan.
  - Dry the back of their legs
  - Dry the perineal area from front to back
  - Finish putting on clothes.
  - Assist the resident to a wheelchair or other preferred surface, changing gloves and performing hand hygiene as soon as the resident is safely seated.
  - Place all linens and soiled gown or clothing in a linen bag or designated hamper.
  - Sanitize the shower chair per facility policy.
  - Remove the gloves, turning them inside out.

4. Post-Procedure Steps:

  - Perform hand hygiene.
  - Check for resident comfort and ask if anything else is needed.
  - Be sure the bed is low and locked. Check the brakes.
  - Place the call light or signaling device within reach of the resident.
  - Open the door and privacy curtain.
  - Perform hand hygiene.
  - Document and report any skin issues or changes noted with the resident.

5.12 Skills Checklist: Tub Bath

1. Gather Supplies: Soap, shampoo and conditioner if used, lotion, four washcloths, four towels, barrier, gloves, clean clothes or gown, and linen bag or hamper
2. Routine Pre-Procedure Steps:
    - Knock on the resident's door.
    - Perform hand hygiene.
    - Maintain respectful, courteous, and professional communication at all times.
    - Introduce yourself and identify the resident.
    - Provide for privacy.
    - Explain the procedure to the resident.
3. Procedure Steps:
    - Keep the resident covered as long as possible and have the resident test the water temperature on their fingers. Assist the resident to the tub per facility protocol. See the subsection in this chapter called "Considerations During Bathing" for comfort measures. Repeatedly check the water temperature throughout the bath.
    - Put on gloves.
    - Wash the client's face with a washcloth and no soap.
    - Put soap on the washcloth and wash the resident starting with their upper body and then their legs.
    - Lift any skin-on-skin areas and wash gently with soap.
    - Perineal care can be performed in the bed prior to the bath. See Skills Checklists 5.18 and 5.19 for perineal care specifics.
    - Wash the client's hair. See the "Shampoo" checklist for specific steps.
    - Drain the tub per facility protocol and rinse the resident.
    - Place warm towels to cover the resident.
    - Pat dry.
    - Ask the resident if they would like lotion. If applying lotion, wear gloves.

- Assist the resident to put on a clean gown or clothes, keeping a dry towel over the back of the shower chair to prevent getting the gown or clothes wet.
- Place nonskid footwear on the client.
- Assist the resident to stand per their care plan.
- Dry the back of their legs.
- Dry the perineal area from front to back.
- Finish putting on clothes.
- Assist the resident to a wheelchair or other preferred surface, changing gloves and performing hand hygiene as soon as the resident is safely seated.
- Place all linens and soiled gown or clothing in a linen bag or designated hamper.
- Sanitize the bath chair per facility policy.
- Remove the gloves by turning them inside out.

4. Post-Procedure Steps:

- Perform hand hygiene.
- Check for resident comfort and ask if anything else is needed.
- Be sure the bed is low and locked. Check the brakes.
- Place the call light or signaling device within reach of the resident.
- Open the door and privacy curtain.
- Perform hand hygiene.
- Document and report any skin issues or changes noted with the resident.

5.13 Skills Checklist: Shampoo

1. Gather Supplies: Shampoo basin if in bed, shampoo, conditioner if used, two washcloths or small towels, one large towel, gloves, and linen bag
2. Routine Pre-Procedure Steps:
    - Knock on the resident's door.
    - Perform hand hygiene.
    - Maintain respectful, courteous, and professional communication at all times.
    - Introduce yourself and identify the resident.
    - Provide for privacy.
    - Explain the procedure to the resident.
3. Procedure Steps:
    - Put on gloves.
    - Place a basin underneath the client's head and neck if they are in bed and place the drain over the garbage can located on the floor.
    - Give the client a dry washcloth or towel to cover their face if desired.
    - Check the water temperature for safety and comfort. Have the resident check the water temperature by placing their hand in the water in the basin or putting a wet washcloth on the back of their hand. Ask the resident if the temperature is comfortable to them.
    - Wet their hair with a wet washcloth or by gently pouring water over their hair.
    - Apply shampoo and lather while massaging scalp gently.
    - Rinse their hair.
    - Apply conditioner if used, massaging the scalp gently.
    - Rinse their hair.
    - Dry their hair gently and style it per the resident's preference.
    - While wearing gloves, empty the equipment.
    - Rinse the equipment.
    - Dry the basin.
    - Return the equipment to storage.

- Dispose of soiled linen in a designated laundry hamper.
- Remove the gloves, turning them inside out.

4. Post-Procedure Steps:

    - Perform hand hygiene.
    - Check for resident comfort and ask if anything else is needed.
    - Ensure the bed is low and locked. Check the brakes.
    - Place the call light or signaling device within reach of the resident.
    - Open the door and privacy curtain.
    - Perform hand hygiene.
    - Document and report any skin or scalp issues or changes noted with the resident.

5.14 Skills Checklist: Foot Care

1. Gather Supplies: Basin, warm water, soap, lotion, two washcloths, one towel, barrier, gloves, and linen bag or hamper
2. Routine Pre-Procedure Steps:

    - Knock on the resident's door.
    - Perform hand hygiene.
    - Maintain respectful, courteous, and professional communication at all times.
    - Introduce yourself and identify the resident.
    - Provide for privacy.
    - Explain the procedure to the resident.

3. Procedure Steps:

    - Put on gloves.
    - Fill a foot basin with warm water and place it on a flat surface with a barrier underneath. Have the resident check the water temperature by placing their hand in the basin or putting a wet washcloth on the back of their hand.
    - Remove their socks.
    - Immerse their feet in warm water for 5 to 20 minutes.
    - Use water and a soapy washcloth.
    - Wash each foot and between the toes.
    - Rinse the entire foot with the wet washcloth, including between the toes.
    - Dry the foot thoroughly, including between the toes.
    - Ask the resident if they would like lotion. If applying lotion, wear gloves.
    - Massage the lotion over the foot but avoid applying any lotion between the toes.
    - Wipe off any excess lotion with a dry towel.
    - Replace the socks or preferred footwear.
    - While wearing gloves, empty the equipment.

- Rinse the equipment.
- Dry the basin.
- Return the equipment to storage.
- Dispose of soiled linen in a designated laundry hamper.
- Remove the gloves, turning them inside out.

4. Post-Procedure Steps:

- Perform hand hygiene.
- Check for resident comfort and ask if anything else is needed.
- Ensure the bed is low and locked. Check the brakes.
- Place the call light or signaling device within reach of the resident.
- Open the door and privacy curtain.
- Perform hand hygiene.
- Document and report any skin or nail issues or changes noted with the resident.

View a YouTube video[1] of an instructor demonstrating foot care:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nurseassist/?p=297#oembed-1

1. Chippewa Valley Technical College. (2022, December 3). Foot Care. [Video]. YouTube. Video licensed under CC BY 4.0. https://youtu.be/gQekzAPHKGY

5.15 Skills Checklist: Nail Care

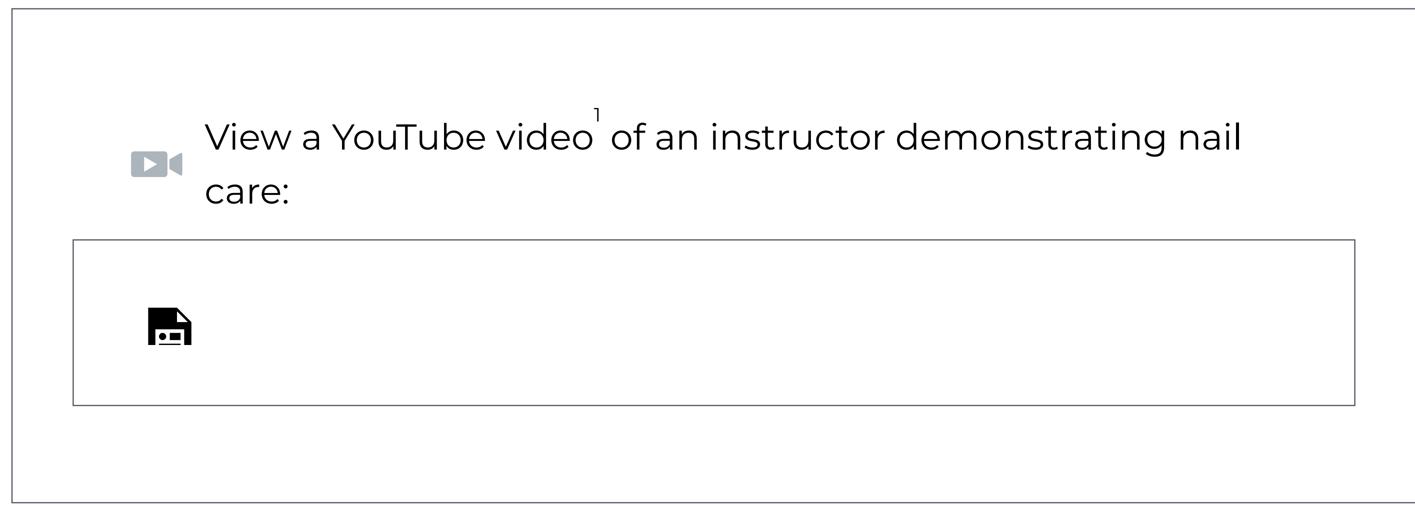
NOTE: Nail care for clients with diabetes should be performed by a Registered Nurse (RN).

1. Gather Supplies: Basin, warm water, soap, lotion, two washcloths, one towel, barrier, gloves, manicure stick, emery board, nail clipper, and linen bag or hamper
2. Routine Pre-Procedure Steps:
    - Knock on the resident's door.
    - Perform hand hygiene.
    - Maintain respectful, courteous, and professional communication at all times.
    - Introduce yourself and identify the resident.
    - Provide for privacy.
    - Explain the procedure to the resident.
3. Procedure Steps:
    - Put on gloves.
    - Fill the basin with warm water and place it on a flat surface with a barrier underneath. Have the resident check the water temperature by placing their hand in the basin or putting a wet washcloth on the back of their hand.
    - Have the resident perform hand hygiene with sanitizer.
    - Immerse the client's hands in warm water for 5 to 20 minutes.
    - Place their hand on a barrier.
    - Using a manicure stick, clean underneath each nail, wiping any debris on the barrier after each nail.
    - If necessary, trim nails using a clipper. Sanitize the clipper prior to and after use.
    - Using an emery board, file each nail from the outside of the nail towards the middle of the nail.
    - Check each nail for snags and file until smooth.

- Rinse the hand in water, return to the barrier, and dry.
- Repeat the procedure for the second hand.
- Offer lotion. If applying lotion, wear gloves.
- Rub the lotion gently into the skin if requested.
- Wipe off any excess lotion with a dry towel.
- While wearing gloves, empty the equipment.
- Rinse the equipment.
- Dry the basin.
- Return the equipment to storage.
- Dispose of soiled linen in a designated laundry hamper.
- Remove the gloves, turning them inside out.

4. Post-Procedure Steps:

    - Perform hand hygiene.
    - Check for resident comfort and ask if anything else is needed.
    - Ensure the bed is low and locked. Check the brakes.
    - Place the call light or signaling device within reach of the resident.
    - Open the door and privacy curtain.
    - Perform hand hygiene
    - Document and report any skin or nail issues or changes noted with the resident.


View a YouTube video[1] of an instructor demonstrating nail care:

1. Chippewa Valley Technical College. (2022, December 3). Nail Care. [Video]. YouTube. Video licensed under CC BY 4.0. https://youtu.be/T32Csl2Rx0s

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nurseassist/?p=299#oembed-1

5.16 Skills Checklist: Skin Care

1. Gather Supplies: Gloves and lotion
2. Routine Pre-Procedure Steps:
    - Knock on the resident's door.
    - Perform hand hygiene and put on gloves.
    - Maintain respectful, courteous, and professional communication at all times.
    - Introduce yourself and identify the resident.
    - Provide for privacy.
    - Explain the procedure to the resident.
3. Procedure Steps:
    - Position the resident as needed and only expose the skin that will be moisturized.
    - Put on gloves.
    - Place a quarter-sized circle of lotion on one palm.
    - Rub the hands together to warm the lotion.
    - Apply the lotion to dry skin but avoid getting lotion between the toes.
    - Use additional lotion, warming between your hands as needed, until all dry skin has been moisturized.
    - Wipe off any excess lotion gently with a dry towel.
    - Remove the gloves, turning them inside out.
4. Post-Procedure Steps:
    - Perform hand hygiene.
    - Check for resident comfort and ask if anything else is needed.
    - Ensure the bed is low and locked. Check the brakes.
    - Place the call light or signaling device within reach of the resident.
    - Open the door and privacy curtain.
    - Perform hand hygiene.
    - Document and report any skin issues or changes noted with the

resident.

It is important to properly clean the wash basin and other supplies after performing any type of skin care to prevent the spread of infection.

View a YouTube video[1] of an instructor demonstrating cleaning supplies after performing skin care:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nurseassist/?p=302#oembed-1

1. Chippewa Valley Technical College. (2022, December 3). Post Skin Care Procedure. [Video]. YouTube. Video licensed under CC BY 4.0. https://youtu.be/yZ_VfxFxUho

5.17 Skills Checklist: Back Rub

1. Gather Supplies: Gloves and lotion
2. Routine Pre-Procedure Steps:

    - Knock on the resident's door.
    - Perform hand hygiene.
    - Maintain respectful, courteous, and professional communication at all times.
    - Introduce yourself and identify the resident.
    - Provide for privacy.
    - Explain the procedure to the resident.

3. Procedure Steps:

    - Put on gloves.
    - Raise the side rail on one side of the bed.
    - Move to the opposite side of the bed and assist the resident to roll towards the raised side rail.
    - Only expose the resident's back from the shoulders to the top of the hips.
    - Place a quarter-sized circle of lotion on one palm.
    - Rub the hands together to warm the lotion.
    - Begin with long, gentle strokes starting at the top of hips and moving to the top of the shoulders. Repeat about five times.
    - Throughout the back rub, ask the resident if there is any pain or discomfort. If pain is present, stop the procedure and report it to the nurse.
    - Apply more lotion to gloved hands as needed to reduce friction on the resident's skin.
    - Make large circles with both hands from the top of hips to the top of shoulders. Repeat about five times.
    - Apply additional lotion to gloved hands as needed to reduce friction on resident's skin.
    - Make small circles with both hands from the top of the hips to the top

of the shoulders. Repeat about five times.
    - Apply additional lotion to gloved hands if needed to reduce friction on resident skin.
    - End with long, gentle strokes starting at the top of hips and moving to the top of shoulders. Repeat about five times.
    - Remove the gloves, turning them inside out.

4. Post-Procedure Steps:

    - Perform hand hygiene.
    - Cover the resident completely per resident preference.
    - Assist the resident to their preferred position.
    - Lower the side rail that was raised.
    - Check for resident comfort and ask if anything else is needed.
    - Ensure the bed is low and locked. Check the brakes.
    - Place the call light or signaling device within reach of the resident.
    - Open the door and privacy curtain.
    - Perform hand hygiene.
    - Document and report any skin issues or changes noted with the resident.

View a YouTube video[1] of an instructor demonstrating a backrub:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nurseassist/?p=304#oembed-1

1. Chippewa Valley Technical College. (2022, December 3). Back Rub. [Video]. YouTube. Video licensed under CC BY 4.0. https://youtu.be/CqFgIrLaQ4M

5.18 Skills Checklist: Perineal Care (Female)

1. Gather Supplies: Basin, warm water, soap, four washcloths, one towel, barrier, gloves, and linen bag or hamper
2. Routine Pre-Procedure Steps:
    - Knock on the resident's door.
    - Perform hand hygiene.
    - Maintain respectful, courteous, and professional communication at all times.
    - Introduce yourself and identify the resident.
    - Provide for privacy.
    - Explain the procedure to the resident.
3. Procedure Steps:
    - Raise one side rail of the bed after checking the resident's mobility and their preferred side to lie on.
    - Put on gloves.
    - Raise the bed height if needed.
    - Fill the basin with warm water and place it on a flat surface with a barrier underneath. Have the resident check the water temperature by placing their hand in the basin or putting a wet washcloth on the back of their hand.
    - Turn the resident or raise their hips and place a barrier (a towel, waterproof soaker pad, disposable pad, etc.) under their buttocks.
    - Expose their perineum only.
    - Separate the labia.
    - Use water and a soapy washcloth.
    - Clean one side of the labia from top to bottom.
    - Using a clean portion of the first washcloth, clean the other side of the labia from top to bottom.
    - Using a clean portion of the first washcloth, clean the vaginal area from top to bottom.
    - Put the first washcloth in the linen bag.

- Using the second clean washcloth, rinse one side of the labia from top to bottom.
- Using a clean portion of the second washcloth, rinse the other side of the labia from top to bottom.
- Using a clean portion of the second washcloth, rinse the vaginal area from top to bottom.
- Put the second washcloth in the linen bag.
- Avoid overexposure throughout the procedure.
- Pat dry.
- Cover the exposed area with the bath blanket.
- Assist the resident to turn onto their side facing away from you and ask the resident to hold onto the raised side rail.
- Using the third clean washcloth, apply water and soap.
- Using a clean portion of the third washcloth, clean one side of the buttock, wiping away from vagina.
- Using a clean portion of the third washcloth, clean the other side of the buttock, wiping away from the vagina.
- Using a clean portion of the third washcloth, clean the rectal area wiping away from the vagina.
- Put the third washcloth in the linen bag.
- Using the fourth washcloth, rinse one side of the buttock wiping away from the vagina.
- Using a clean portion of the fourth washcloth, rinse the other side of the buttock wiping away from the vagina.
- Using a clean portion of the fourth washcloth, rinse the rectal area wiping away from vagina.
- Put the fourth washcloth in the linen bag.
- Pat dry.
- Safely remove the waterproof pad from under the buttocks.
- Remove the gloves, turning them inside out.
- Perform hand hygiene.
- Position the resident on her back.
- Put on clean gloves.
- Dispose of soiled linen in the designated laundry hamper.

- Empty the equipment.
- Rinse the equipment.
- Dry the equipment.
- Return the equipment to storage.
- Remove the gloves, turning them inside out.
- Dispose of the gloves in an appropriate container.

4. Post- Procedure Steps:

- Perform hand hygiene.
- Check for resident comfort and ask if anything else is needed.
- Ensure the bed is low and locked. Check the brakes.
- Place the call light or signaling device within reach of the resident.
- Open the door and privacy curtain.
- Perform hand hygiene.
- Document and report any skin issues or changes noted with the resident.

View a YouTube video[1] of an instructor demonstrating female perineal care:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nurseassist/?p=307#oembed-1

1. Chippewa Valley Technical College. (2022, December 3). Perineal Care (Female). [Video]. YouTube. Video licensed underCC BY 4.0. https://youtu.be/6Xu2Sgk1y80

5.19 Skills Checklist: Perineal Care (Male)

1. Gather Supplies: Basin, warm water, soap, four washcloths, one towel, barrier, gloves, and linen bag or hamper
2. Routine Pre-Procedure Steps:
    - Knock on the resident's door.
    - Perform hand hygiene.
    - Maintain respectful, courteous, and professional communication at all times.
    - Introduce yourself and identify the resident.
    - Provide for privacy.
    - Explain the procedure to the resident.
3. Procedure Steps:
    - Raise one side rail of the bed. Check the resident's mobility and their preferred side to lie on.
    - Put on gloves.
    - Raise the bed height if needed.
    - Fill the basin with warm water and place it on a flat surface with a barrier underneath. Have the resident check the water temperature by placing their hand in the basin or putting a wet washcloth on the back of their hand.
    - Turn the resident or raise the hips and place a barrier (a towel, waterproof soaker pad, disposable pad, etc.) under their buttocks.
    - Expose the perineum only.
    - Use water and a soapy washcloth.
    - If the resident is not circumcised, gently move the foreskin away from their urethra toward the base of the penis.
        - Using a clean portion of the first washcloth, start from the urethra and clean in a circular motion toward their scrotum.
        - Using a clean portion of the first washcloth, clean one groin fold and the scrotum.

        - Using a clean portion of the first washcloth, clean the other groin fold and the other side of scrotum.
        - Put the first washcloth in a linen bag.
        - Using the second clean washcloth, rinse from the urethra in a circular motion toward the scrotum.
        - Using a clean portion of the second washcloth, rinse one groin fold and the scrotum.
        - Using a clean portion of the second washcloth, rinse the other groin fold and the other side of the scrotum.
        - Put the second washcloth in the linen bag.
        - Avoid overexposure throughout the procedure.
        - Pat dry.
    - If uncircumcised, gently return the foreskin toward the urethra.
        - Cover the exposed area with the bath blanket.
        - Assist the resident to turn onto their side away from you and ask the resident to hold onto the raised side rail.
        - Using the third clean washcloth, apply water and soap.
        - Using a clean portion of the third washcloth, clean one side of the buttock wiping away from the urethra.
        - Using a clean portion of the third washcloth, clean the other side of the buttock wiping away from the urethra.
        - Using a clean portion of the third washcloth, clean the rectal area wiping away from the urethra.
        - Put the third washcloth in the linen bag.
        - Using the fourth washcloth, rinse one side of the buttock wiping away from the urethra.
        - Using a clean portion of the fourth washcloth, rinse the other side of the buttock wiping away from the urethra.
        - Using a clean portion of the fourth washcloth, rinse the rectal area wiping away from the urethra.
        - Put the fourth washcloth in the linen bag.
        - Pat dry.
    - Safely remove the waterproof pad from under the buttocks.
    - Remove the gloves, turning them inside out.

- Perform hand hygiene.
- Position the resident on his back.
- Put on clean gloves.
- Dispose of soiled linen in the designated laundry hamper.
- Empty the equipment.
- Rinse the equipment.
- Dry the equipment.
- Return the equipment to storage.
- Remove the gloves, turning them inside out.
- Dispose of gloves in an appropriate container.

4. Post-Procedure Steps:

    - Perform hand hygiene.
    - Check for resident comfort and ask if anything else is needed.
    - Ensure the bed is low and locked. Check the brakes.
    - Place the call light or signaling device within reach of the resident.
    - Open the door and privacy curtain.
    - Perform hand hygiene.
    - Document and report any skin issues or changes noted with the resident.

View a YouTube video[1] of an instructor demonstrating male perineal care:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nurseassist/?p=309#oembed-1

1. Chippewa Valley Technical College. (2022, December 3). Perineal Care (Male). [Video]. YouTube. Video licensed under CC BY 4.0. https://youtu.be/n3Ed36YSz9w

5.20 Skills Checklist: Oral Care

1. Gather Supplies: Gloves, toothbrush, toothpaste, emesis/oral basin, cup of water, clothing protector (towel), barrier (paper towel), and linen bag or hamper
2. Routine Pre-Procedure Steps:
    - Knock on the resident's door.
    - Perform hand hygiene.
    - Maintain respectful, courteous, and professional communication at all times.
    - Introduce yourself and identify the resident.
    - Provide for privacy.
    - Explain the procedure to the resident.
3. Procedure Steps:
    - Place all supplies on a barrier.
    - Put on gloves.
    - If the resident is in bed, elevate the head of the bed if it is permissible per the care plan.
    - Cover the resident's chest with a towel to keep their clothing or gown clean.
    - Wet the toothbrush in the sink or in a cup of water.
    - Apply a small amount of toothpaste to the toothbrush.
    - Brush the resident's teeth, including the inner, outer, and chewing surfaces of all upper and lower teeth.
    - After each quadrant of the mouth (i.e., lower right, lower left, upper right, or upper left), allow the resident to rinse with water and spit into an emesis basin if needed.
    - Clean the resident's tongue being careful not to cause the resident to gag.
    - Assist the resident in rinsing their mouth.
    - Wipe the resident's mouth with the towel on their chest.
    - Remove the towel and place it in a linen bag.

- Empty the emesis basin.
- Rinse the emesis basin.
- Dry the emesis basin.
- Rinse the toothbrush.
- Return the equipment to storage.
- Remove the gloves, turning them inside out.
- Dispose of the gloves in an appropriate container.

4. Post-Procedure Steps:

- Perform hand hygiene.
- Check for resident comfort and ask if anything else is needed.
- Ensure the bed is low and locked. Check the brakes.
- Place the call light or signaling device within reach of the resident.
- Open the door and privacy curtain.
- Perform hand hygiene.
- Document and report any oral issues or changes noted with the resident.

View a YouTube video[1] of an instructor demonstrating oral care:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nurseassist/?p=311#oembed-1

1. Chippewa Valley Technical College. (2022, December 3). Oral Care. [Video]. YouTube. Video licensed under CC BY 4.0. https://youtu.be/SQEjgHODEz0

5.21 Skills Checklist: Denture Care

1. Gather Supplies: Gloves, denture brush, denture toothpaste if available, dentures, denture cup, denture cleansing tablet if desired, emesis/oral basin, oral swab, cup of water, clothing protector (towel), barrier (paper towel), sink liner (paper towel or washcloth), and linen bag or hamper. See Figure 5.26[1] at the end of this checklist for an image of an oral swab.
2. Routine Pre-Procedure Steps:
    - Knock on the resident's door.
    - Perform hand hygiene.
    - Maintain respectful, courteous, and professional communication at all times.
    - Introduce yourself and identify the resident.
    - Provide for privacy.
    - Explain the procedure to the resident.
3. Procedure Steps:
    - Put on gloves.
    - Place all supplies on a barrier.
    - Place a clothing protector on the resident.
    - Line the sink with a washcloth or paper towel.
    - Remove dentures from the cup or remove them from the resident's mouth and place them in the denture cup or emesis basin.
    - Handle the dentures carefully to avoid damage or contamination.
    - Wet the denture brush and apply denture toothpaste if available. Water alone is acceptable to clean dentures if toothpaste is not available.
    - Thoroughly brush the inner, outer, and chewing surfaces of each denture.
    - Rinse the dentures using clean, cool water and place them on a clean

1. "Oral Swab" by Landon Cerny is licensed under CC BY 4.0

barrier or in an emesis basin.
    - Rinse the denture cup.
    - Place the dentures in a rinsed cup.
    - Wet an oral swab and gently clean all surfaces of the resident's gums and tongue.
    - Allow the resident to rinse and spit into the emesis basin.
    - Place the dentures in the resident's mouth if desired.
    - Wipe the resident's mouth and remove the clothing protector, placing it in an appropriate container.
    - In the evening, place the dentures in the denture cup and add cool, clean water to the denture cup to cover the dentures.
    - Put a denture cleansing tablet in the cup, if desired.
    - Rinse the equipment (denture brush and emesis basin).
    - Return the equipment to storage.
    - Discard the protective lining in an appropriate container.
    - Remove the gloves, turning them inside out.

4. Post-Procedure Steps:

    - Perform hand hygiene.
    - Check for resident comfort and ask if anything else is needed.
    - Ensure the bed is low and locked. Check the brakes.
    - Place the call light or signaling device within reach of the resident.
    - Open the door and privacy curtain.
    - Perform hand hygiene.
    - Document and report any oral issues or changes noted with the resident.

Figure 5.26 Oral Swab

View a YouTube video[2] of an instructor demonstrating denture care:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nurseassist/?p=313#oembed-1

2. Chippewa Valley Technical College. (2022, December 3). Denture Care. [Video]. YouTube. Video licensed under CC BY 4.0. https://youtu.be/kDWlh3IRGnk

5.22 Skills Checklist: Preparing Clients for Meals and Assisting With Feeding

1. Gather Supplies: Clothing protector, meal, diet card, eating utensils, sanitizer or soapy and wet washcloths
2. Routine Pre-Procedure Steps:
    - Knock on the resident's door unless they are in the dining room.
    - Perform hand hygiene.
    - Maintain respectful, courteous, and professional communication at all times.
    - Introduce yourself and identify the resident.
    - Explain the procedure to the resident.
3. Procedure Steps:
    - Verify the name on the diet card matches the resident.
    - Verify the diet, diet texture, and liquid consistency matches the diet card.
    - Position the resident in an upright position, at least 45 degrees.
    - Place a clothing protector on the resident if desired (e.g., a paper or cloth towel or a large napkin).
    - Ask the resident if they would like oral care before eating.
    - Assist the resident to clean their hands before feeding using sanitizer or soapy and wet washcloths.
    - Position yourself at eye level facing the resident.
    - Describe the foods and fluids being offered to the resident.
    - Offer small amounts of food at a reasonable rate.
    - Offer fluids frequently.
    - Allow the resident time to chew and swallow.
    - Wipe the resident's face whenever necessary.
    - Continue to alternate foods and fluids until the resident indicates they are full.
    - Clean the resident's face and hands.
    - Ask the resident if they would like oral care.

- Leave the resident with their head elevated at least 30 degrees.

4. Post-Procedure Steps:

    - Perform hand hygiene.
    - Record the intake as a percentage of total solid food eaten.
    - Record the sum of estimated fluid intakes in mL or cc.
    - Check for resident comfort and ask if anything else is needed.
    - If in the resident's room, ensure the bed is low and locked. Check the brakes.
    - Place the call light or signaling device within reach of the resident.
    - Open the door and privacy curtain.
    - Perform hand hygiene.
    - Document and report any feeding issues or changes noted with the resident.

View a YouTube video[1] of an instructor demonstrating preparing clients for meals and assistance with feeding:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nurseassist/?p=316#oembed-1

1. Chippewa Valley Technical College. (2022, December 3). Preparing Clients for Meals and Assistance With Feeding. [Video]. YouTube. Video licensed under CC BY 4.0. https://youtu.be/Yt3EelUdy60

5.23 Skills Checklist: Choking Maneuver

1. Call out for help or tell another staff member to get the nurse if you think a resident is choking. If no nurse is available, direct someone to call 911 while proceeding with the following steps.
2. Until help arrives, stand behind the victim with one leg forward between the victim's legs.
3. For a child, move down to their level and keep your head to one side.
4. Reach around their abdomen and locate the navel.
5. Place the thumb side of your fist against their abdomen just above the navel.
6. Grasp your fist with your other hand and thrust inward and upward into the victim's abdomen with quick jerks.
7. For a responsive pregnant victim, any victim you cannot get your arms around, or for anyone in whom abdominal thrusts are not effective, give chest thrusts while standing behind them. Avoid squeezing the ribs with your arms.
8. Continue thrusts until the victim expels the object or becomes unresponsive.
9. If the person becomes unconscious, notify the nurse. If no nurse is available, call 911.

View a YouTube video[1] of an instructor demonstrating the choking maneuver:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nurseassist/?p=318#oembed-1

1. Chippewa Valley Technical College. (2022, December 3). Choking Maneuver. [Video]. YouTube. Video licensed under CC BY 4.0. https://youtu.be/HMtwmw5Vaoo

5.24 Skills Checklist: Catheter Care

1. Gather Supplies: Basin, warm water, soap, two washcloths, one towel, barrier, gloves, and linen bag or hamper
2. Routine Pre-Procedure Steps:
    - Knock on the resident's door.
    - Perform hand hygiene.
    - Maintain respectful, courteous, and professional communication at all times.
    - Introduce yourself and identify the resident.
    - Provide for privacy.
    - Explain the procedure to the resident.
3. Procedure Steps:
    - Put on gloves.
    - Fill the basin with warm water and place it on a flat surface with a barrier underneath. Have the resident check the water temperature by placing their hand in the basin or putting a wet washcloth on the back of their hand.
    - Raise the bed height to a working height.
    - Expose only the urethra and catheter.
    - Follow the tubing from the resident toward the drainage bag, ensuring that the tubing is at a lower level as it goes toward the bag. Be sure no kinks or elevation can cause backflow to the bladder.
    - Turn the resident or raise their hips and place a barrier (e.g., a towel, waterproof soaker pad, or disposable pad) under their buttocks.
    - Use the first washcloth with soap and water to carefully wash around the catheter where it exits the urethra.
    - Hold the catheter where it exits the urethra with one hand.
    - While holding the catheter, clean 3-4 inches down the catheter tube.
    - Clean with strokes moving away from the urethra.
    - Use a clean portion of washcloth for each stroke.
    - Put the soiled first washcloth in the linen bag.

- Wet the second washcloth and rinse, using strokes only away from the urethra while continuing to hold the catheter where it exits the urethra.
- Rinse using a clean portion of washcloth for each stroke.
- Put the soiled second washcloth in the linen bag.
- Pat dry with a towel.
- Do not allow the tube to be pulled at any time during the procedure.
- Replace the gown over the resident's perineal area.
- While wearing gloves, empty the basin.
- Rinse the basin.
- Dry the basin.
- Return the equipment to storage.
- Dispose of soiled linen in a designated laundry hamper.
- Remove the gloves, turning them inside out.

4. Post-Procedure Steps:

    - Perform hand hygiene.
    - Check for resident comfort and ask if anything else is needed.
    - Ensure the bed is low and locked. Check the brakes.
    - Place the call light or signaling device within reach of the resident.
    - Open the door and privacy curtain.
    - Perform hand hygiene.
    - Document and report any issues or changes noted with the resident.

View a YouTube video[1] of an instructor demonstrating catheter care:

1. Chippewa Valley Technical College. (2022, December 3). Catheter Care. [Video]. YouTube. Video licensed under CC BY 4.0. https://youtu.be/pIM5rRt9s-w

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nurseassist/?p=320#oembed-1

5.25 Skills Checklist: Emptying Catheter Drainage Bag

1. Gather Supplies: Gloves, two barriers, graduated cylinder, and alcohol swab
2. Routine Pre-Procedure Steps:
   - Knock on the resident's door.
   - Perform hand hygiene.
   - Maintain respectful, courteous, and professional communication at all times.
   - Introduce yourself and identify the resident.
   - Provide for privacy.
   - Explain the procedure to the resident.
3. Procedure Steps:
   - Put on gloves.
   - Place a barrier (e.g., paper towel or disposable pad) on the floor under the drainage bag.
   - Place the graduated cylinder on the barrier.
   - Open the drain to allow the urine to flow into the graduated cylinder.
   - Avoid touching the tip of the tubing to the sides of the graduated cylinder.
   - Close the drain.
   - Wipe the drain with an alcohol wipe.
   - Wipe the drain holder, if present, with an alcohol wipe.
   - Replace the drain into the holder.
   - Place a clean barrier on a level, flat surface.
   - Place the graduated cylinder on the barrier.
   - With the graduated cylinder at eye level, read the amount of output.
   - Note the characteristics (i.e., color, clarity, sediment, or unusual odor) of the urine.
   - Empty the urine in the graduated cylinder into the toilet.
   - Rinse the graduated cylinder and empty it into the toilet.
   - Return the equipment to storage.

- Remove the gloves, turning them inside out.

4. Post-Procedure Steps:

    - Perform hand hygiene.
    - Check for resident comfort and if anything else is needed.
    - Ensure the bed is low and locked. Check the brakes.
    - Place the call light or signaling device within reach of the resident.
    - Open the door and privacy curtain.
    - Perform hand hygiene.
    - Document urinary output in mL and report any issues or changes noted with the resident.

View a YouTube video[1] of an instructor demonstrating emptying catheter drainage bag:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nurseassist/?p=322#oembed-1

1. Chippewa Valley Technical College. (2022, December 3). Emptying Catheter Drainage Bag. [Video]. YouTube. Video licensed under CC BY 4.0. https://youtu.be/V2Xq4GWcfow

5.26 Skills Checklist: Assisting With a Bedpan

1. Gather Supplies: Gloves, bedpan, barrier, and toilet tissue
2. Routine Pre-Procedure Steps:
    - Knock on the client's door.
    - Perform hand hygiene.
    - Maintain respectful, courteous, and professional communication at all times.
    - Introduce yourself and identify the resident.
    - Provide for privacy.
    - Explain the procedure to the client.
3. Procedure Steps:
    - Put on gloves.
    - Turn the resident or raise their hips and place a barrier (e.g., a towel, waterproof soaker pad, disposable pad) under their buttocks.
    - Position the resident on the bedpan/fracture pan correctly. The deeper portion of the bedpan should be directed toward their toes, and the resident should be centered on the bedpan. For fracture bedpans, the handle should be directed toward their toes.
    - Raise the head of the bed to a comfortable level.
    - Cover the resident with linens or a bath blanket.
    - Leave toilet tissue within reach of the resident.
    - Leave the call light within reach of the resident.
    - Wait nearby allowing for resident privacy.
    - When the resident signals, return and assist the resident to perform hand hygiene.
    - Discard the soiled linen in the designated laundry hamper.
    - Gently remove the bedpan/fracture pan.
    - Assist with perineal care.
    - Empty the bedpan into the toilet or into a graduated cylinder if output is being recorded. Note the amount and characteristics (i.e., color, clarity, sediment, or unusual odor) of the urine. Empty the urine

from the graduated cylinder used into the toilet.
  - Rinse the equipment used and empty the rinse water into the toilet.
  - Remove the gloves, turning them inside out.

4. Post-Procedure Steps:

   - Perform hand hygiene.
   - Check for resident comfort and ask if anything else is needed.
   - Ensure the bed is low and locked. Check the brakes.
   - Place the call light or signaling device within reach of the resident.
   - Open the door and privacy curtain.
   - Perform hand hygiene.
   - Document urinary output in mL and report any issues or changes noted with the resident.

View a YouTube video[1] of an instructor demonstrating assisting with a bedpan:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nurseassist/?p=324#oembed-1

1. Chippewa Valley Technical College. (2022, December 3). Assisting with a Bedpan. [Video]. YouTube. Video licensed under CC BY 4.0. https://youtu.be/WCg57s4HGhc

5.27 Skills Checklist: Assisting With a Urinal

1. Gather Supplies: Gloves, urinal, and barrier
2. Routine Pre-Procedure Steps:
    - Knock on the resident's door.
    - Perform hand hygiene.
    - Maintain respectful, courteous, and professional communication at all times.
    - Introduce yourself and identify the resident.
    - Provide for privacy.
    - Explain the procedure to the resident.
3. Procedure Steps:
    - Put on gloves.
    - Assist the resident to their preferred position of comfort and mobility status (e.g., seated on the side of the bed, lying in bed, or standing).
    - Place the urinal with the shaft of the penis well within the opening. Keep the urinal level to prevent urine spillage while the resident is urinating. If the resident has discomfort, a washcloth can be placed around the rim of the urinal to prevent skin issues.
    - Provide privacy while the resident voids.
    - Place a barrier on a flat surface.
    - Place the urinal on the barrier.
    - With the urinal at eye level, read the amount of urine and note its characteristics (i.e., color, clarity, sediment, or unusual odor).
    - Empty the urinal into the toilet.
    - Rinse the urinal and empty the rinse water into the toilet.
    - Return the urinal to storage.
    - Remove the gloves, turning them inside out.
4. Post-Procedure Steps:
    - Perform hand hygiene.

- Check for resident comfort and ask if anything else is needed.
- Ensure the bed is low and locked. Check the brakes.
- Place the call light or signaling device within reach of the resident.
- Open the door and privacy curtain.
- Perform hand hygiene.
- Document urinary output in mL and report any skin issues or changes noted with the resident.

View a YouTube video[1] of an instructor demonstrating assisting with a urinal:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nurseassist/?p=326#oembed-1

1. Chippewa Valley Technical College. (2022, December 3). Assisting with a Urinal. [Video]. YouTube. Video licensed under CC BY 4.0. https://youtu.be/bLtm0TLEAFk

5.28 Skills Checklist: Changing Incontinence Brief

1. Gather Supplies: Gloves and brief
2. Routine Pre-Procedure Steps:
    - Knock on the resident's door.
    - Perform hand hygiene.
    - Maintain respectful, courteous, and professional communication at all times.
    - Introduce yourself and identify the resident.
    - Provide for privacy.
    - Explain the procedure to the resident.
3. Procedure Steps:
    - Put on gloves.
    - If the resident is in bed, raise one side rail.
    - Moving to the opposite side of bed, assist the resident to raise their hips or turn towards the side rail. Remove the soiled brief.
    - Remove the gloves, turning them inside out.
    - Perform hand hygiene.
    - Put on gloves.
    - Assist with perineal care.
    - Remove the gloves, turning them inside out.
    - Perform hand hygiene.
    - Put on gloves.
    - Place a new brief under the resident's buttocks and center the brief. Gently tuck the tabs under the resident.
    - Assist the resident to roll onto their back.
    - Position the brief over the front of the resident and secure the brief with tabs.
    - Remove the gloves, turning them inside out.
4. Post-Procedure Steps:

- Perform hand hygiene.
- Check for resident comfort and ask if anything else is needed.
- Ensure the bed is low and locked. Check the brakes.
- Place the call light or signaling device within reach of the resident.
- Open the door and privacy curtain.
- Perform hand hygiene.
- Document output from the soiled brief and report any skin issues or changes noted with the resident.

View a YouTube video[1] of an instructor demonstrating changing incontinence brief:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nurseassist/?p=329#oembed-1

1. Chippewa Valley Technical College. (2022, December 3). Changing Incontinence Brief. [Video]. YouTube. Video licensed under CC BY 4.0. https://youtu.be/1Ue22ysFyqQ

5.29 Skills Checklist: Dressing A Client Who Needs Total Assistance

1. Gather Supplies: Resident clothing, socks and footwear, and hamper
2. Routine Pre-Procedure Steps:
    - Knock on the resident's door.
    - Perform hand hygiene.
    - Maintain respectful, courteous, and professional communication at all times.
    - Introduce yourself and identify the resident.
    - Provide for privacy.
    - Explain the procedure to the resident.
3. Procedure Steps:
    - Raise the bed height.
    - Keep the resident covered while removing their gown.
    - Remove the gown from the unaffected (most mobile) side first.
    - Place the used gown in a designated laundry hamper.
    - Ask the resident their preferences for desired clothing.
    - Start dressing them on their affected (least mobile) side first. Insert their hand through the sleeve of their shirt and grasp the hand of the resident to guide it through the sleeve.
    - Put pants on both legs, starting with the affected (least mobile) side first. If the resident is able, assist them to raise their buttocks. If they are unable to raise their hips, put the side rail on their unaffected (most mobile) side up. Assist the resident to turn towards the side rail. Pull the pants over their buttocks and up to their waist.
    - While still on the unaffected (most mobile) side, tuck the resident's shirt underneath their unaffected side.
    - Assist the resident onto their back.
    - Raise the side rail if the resident is unable to lift their hips.
    - Move to the unaffected side of the resident.
    - Place their unaffected arm in the shirt sleeve, grasping the hand of

the resident. Finish putting on their shirt by buttoning and zipping closures.

- Assist the resident to turn onto their affected side and pull their pants up to their waist.
- Return the resident to lying on their back.
- Put on the resident's socks. Draw the socks up the resident's foot until they are smooth.
- Put on the resident's nonskid footwear by slipping each nonskid footwear on the resident's feet.
- Leave only when the resident is properly dressed.

4. Post-Procedure Steps:

- Check for resident comfort and ask if anything else is needed.
- Ensure the bed is low and locked. Check the brakes.
- Place the call light or signaling device within reach of the resident.
- Open the door and privacy curtain.
- Perform hand hygiene.
- Document and report any skin issues or changes noted with the resident.

View a YouTube video[1] of an instructor demonstrating dressing a client who needs total assistance:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nurseassist/?p=331#oembed-1

1. Chippewa Valley Technical College. (2022, December 3). Dressing a Client Who Needs Total Assistance. [Video]. YouTube. Video licensed under CC BY 4.0. https://youtu.be/StcnLjYQBtY

5.30 Skills Checklist: Shaving With an Electric Razor

1. Gather Supplies: Gloves, clothing protector (towel), razor, and hamper
2. Routine Pre-Procedure Steps:
    - Knock on the resident's door.
    - Perform hand hygiene.
    - Maintain respectful, courteous, and professional communication at all times.
    - Introduce yourself and identify the resident.
    - Provide for privacy.
    - Explain the procedure to the resident.
3. Procedure Steps:
    - Put on gloves.
    - Sit the resident upright and place a clothing protector over their chest.
    - Hold the shaver at a right angle to the resident's face, using your free hand to pull their skin taught as you shave. This will minimize snagging and the risk of cutting the resident.
    - Shave all areas of the face and neck per resident preference.
    - Gather the clothing protector so their whiskers do not fall onto their clothing.
    - Place the clothing protector in the designated hamper.
    - Clean the razor per facility guidelines and charge or plug it in.
    - Remove the gloves, turning them inside out.
4. Post-Procedure Steps:
    - Perform hand hygiene.
    - Check for resident comfort and ask if anything else is needed.
    - Ensure the bed is low and locked. Check the brakes.
    - Place the call light or signaling device within reach of the resident.
    - Open the door and privacy curtain.

- Perform hand hygiene.
- Document and report any skin issues or changes noted with the resident.

View a YouTube video[1] of an instructor demonstrating shaving with an electric razor:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nurseassist/?p=333#oembed-1

1. Chippewa Valley Technical College. (2022, December 3). Shaving with an Electric Razor. [Video]. YouTube. Video licensed under CC BY 4.0. https://youtu.be/ShawTlxf1o8

5.31 Learning Activities

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=344#h5p-28

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=344#h5p-39

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nurseassist/?p=344#h5p-41

V Glossary

Activities of daily living (ADLs): Hygiene, grooming, dressing, fluid and nutritional intake, mobility, and elimination needs of clients.

A.M. care: Personal care performed in the morning.

Aspiration: Inadvertently breathing fluid or food into the airway instead of swallowing it.

Clock method: A method used with clients with visual impairments to describe where the food on their plate is located. For example, state, "Your mashed potatoes are at 10 o'clock, the green beans are at 2 o'clock, and the meat loaf is at 6 o'clock on your plate."

CLOWD: An acronym to consider after providing personal care but before leaving the room that stands for Comfort; Light, Lock and Low; Open; Wash; and Document.

Colostomy: A surgically placed opening when a client's colon function is impaired. A piece of the colon is diverted to an artificial opening in the abdominal wall called a stoma, and feces is collected in a pouch.

Commode: A movable device with a bucket underneath the seat that is used for elimination when the client has difficulty getting to the bathroom.

Complete bed bath: A bath provided in bed for clients who have difficulty getting out of bed, are experiencing excessive pain, or have other physical or cognitive issues that make other types of bathing less tolerable.

Grooming: Maintaining a resident's appearance through shaving, hair, and nail care.

Hygiene: Keeping the body clean and reducing pathogens by performing tasks such as bathing and oral care.

Impaired skin integrity: Skin that is damaged or not healing normally. An

example of impaired skin integrity is a pressure injury (also called a bedsore or pressure ulcer) with damage to the skin and surrounding tissue.

Incontinence briefs or pads: Disposable products used for clients with little to no control over bladder or bowel function.

Partial bath: Washing the face, underarms, arms, hands, and perineal area. Partial baths are given daily to maintain hygiene. They preserve skin integrity by not drying out skin with excessive soap and water use.

Perineal: The genital and anal area.

Personal care: Care that a client needs to maintain hygiene, well-being, self-esteem, and dignity.

Person-centered care: A care approach that considers the whole person, not just their physical and medical needs. It also refers to a person' autonomy to make decisions about their care, as well as participate in their own care.

P.M. care: Personal care performed in the evening.

Pureed diet: A diet order indicating all food is blended to smooth consistency.

Routine cares: Personal cares provided to every resident every day, such as assisting them in getting dressed for breakfast.

Sepsis: Life-threatening infection that has spread throughout the body.

SKWIPE: An acronym to consider before providing cares to clients that stands for Supplies, Knock, Wash, Introduce, Privacy, and Explain.

Timed voiding: Encourages the patient to urinate on a set schedule.

Urge incontinence: A condition where as soon as the person feels the need to empty their bladder they have very little time before urine escapes.

Urinary catheter: A device placed into the bladder by a nurse using sterile technique that allows the urine to drain into a collection bag.

Urinary tract infection (UTI): A common infection that occurs when bacteria, typically from the rectum, enter the urethra and infect the bladder or kidneys.

Urostomy: A surgically placed opening to collect urine from a person's ureters when their bladder is diseased or has been removed. Urostomies are typically located on the lower right side of the abdomen, and urine is collected into a drainage bag.

Wet voice: Vocalization with sounds as if food or fluids remain in the mouth or throat.

PART VI

CHAPTER 6: PROVIDE FOR BASIC NURSING CARE NEEDS

6.1 Introduction to Provide for Basic Nursing Care Needs

Learning Objectives

- Carry out the basic nursing skills required for the nursing assistant
- Adapt care to meet the physical needs of the aging client
- Apply heat and cold applications
- Administer nonprescription (OTC) medications
- Define the principles of nutrition and fluid needs
- Provide client comfort measures
- Assist with end-of-life care for the dying client
- Assist with postmortem care
- Recognize the general effects of prescribed routine medications

The general scope of practice for nursing assistants (NAs) relates to helping individuals with their activities of daily living (ADLs), including facilitating fluid and nutritional intake. NAs also complete actions that provide comfort and increase clients' quality of life. **Quality of life** refers to the degree to which an individual is healthy, comfortable, and able to participate in or enjoy life events.

Nurses may delegate actions to nursing assistants that provide comfort to residents, such as application of nonprescription, topical medications or heat and cold treatments. Nursing assistants may also provide care to residents in special situations, such as end-of-life care or postmortem care. End-of-life care is a term used to describe care provided when death is imminent and life expectancy is limited to a short number of hours or days. **Postmortem care** refers to care provided after death has occurred through transfer to a morgue

or funeral provider. Knowing how to safely and respectfully implement these delegated interventions is essential.

6.2 Nutrition and Fluid Needs

Nursing assistants (NAs) help clients meet their nutritional and fluid needs as they assist them with their activities of daily living. Let's begin by reviewing the anatomy and physiology of the gastrointestinal system.

Anatomy and Physiology of the Gastrointestinal System

The gastrointestinal system (also referred to as the digestive system) is responsible for several functions, including digestion, absorption, and immune response. Digestion begins at the mouth, where chewing of food occurs. This is called mechanical digestion. If food is not broken down mechanically by the teeth, it is very difficult to digest, and it also increases the risk of choking. If there are any concerns with missing or broken teeth, dentures that don't fit well, or any pain or open areas in the mouth, the NA should report these concerns to the nurse immediately.

After food is chewed and swallowed, it goes into the stomach via the esophagus. Involuntary movement, called peristalsis, allows the food to enter the stomach to mix with acidic gastric juices. The breaking down of food with these acids is called chemical digestion. From the stomach, the liquid food (called chyme) passes through the small and large intestine where nutrients and water are absorbed into the bloodstream. Waste products are condensed into feces and excreted through the anus.[1,2] More information on the structure and function of the digestive system will be covered in Chapter 11.

Appropriate food and fluid intake are essential to good health, so anything that potentially decreases a client's appetite must be addressed. For example, all five senses decline in functioning to some extent in older adults. It is important for the NA to provide accommodations that address these declines in sensory function that can impact food intake and overall health. Enhancing

1. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0
2. This work is a derivative of Anatomy and Physiology by Boundless and is licensed under CC BY-SA 4.0

food intake in older adults with altered sensory function includes the following accommodations:

- **Vision**
  - If the resident is known to wear glasses, ensure they are wearing them, and the lenses are clean. Seeing food often stimulates the desire to eat.
  - Explain what is on the meal tray if the client has significant visual impairment. It is helpful to use the “clock method,” such as, “On your plate, your peas are at 3 o’clock, your roast beef is at 6 o’clock, and your mashed potatoes are at 9 o’clock.”
  - If a resident has a pureed diet order, review their menu so you can describe each type of food in an appealing manner.
  - Make meals look as attractive as possible. Take food off trays and avoid using plastic utensils and disposable cups whenever possible so the resident feels as if they are having a meal at home.
- **Hearing**
  - If the resident has hearing aids, ensure they are in place, charged, and functioning so they can hear you describe the food.
  - Ask if music is preferred during mealtime.
  - When seating residents in a public eating area, ensure they are seated with others with similar cognitive status so they may enjoy conversation while eating.
- **Touch**
  - Encourage the resident to eat as independently as possible by using adaptive silverware or other meal aids. Occupational therapists can assess the needs of the resident and provide adaptive equipment.
  - If utensils can’t be held by the resident, try using finger foods such as fruit, bread, or crackers.
- **Smell**

    - If possible, dietary staff should prepare meals near resident rooms because the aroma of cooking food may increase hunger.
    - If a client is eating a meal in their room, clear the room of unpleasant odors or sights. For example, empty the trash can if it has soiled incontinence products, and empty urinals that may be sitting on side tables.

- **Taste**
    - Check the diet order. If the order permits, ask residents if they prefer seasoning or condiments.
    - Ensure hot foods are served hot and cold foods are served cold. Judge the temperature of the food by placing your hand above the food to sense heat, but do not touch the food directly with your hand. Rewarm hot foods that have cooled.
    - If the resident does not like the meal choice, find an alternative food that appeals to them.

Refer to the "Assisting With Nutrition and Fluid Needs" section and the checklist "Preparing Clients for Meals and Assisting With Feeding" in Chapter 5 for specific steps and additional insight on feeding a dependent client.

Macronutrients

In hospitals and long-term care facilities, the dietician assesses clients periodically to ensure that their nutritional and fluid needs are met. However, when providing care in a group home, assisted living, or home health, NAs are often responsible for creating meals. It is important to understand basic nutritional concepts so you can address your clients' nutritional needs.

Macronutrients make up most of a person's diet and provide energy, as well as essential nutrient intake. Macronutrients include carbohydrates, proteins, and fats. However, too many macronutrients without associated physical activity cause excess nutrition that can lead to obesity, cardiovascular disease,

diabetes mellitus, kidney disease, and other chronic diseases. Conversely, too few macronutrients contribute to nutrient deficiencies and malnourishment.[3]

Carbohydrates are sugars and starches and are an important energy source. Each gram of carbohydrates provides four calories. Carbohydrates break down into glucose and raise blood sugar levels. Diabetics should limit carbohydrate intake to maintain blood sugar levels in a healthy range.

Proteins are peptides and amino acids that provide four calories per gram. Proteins are necessary for tissue repair and function, growth, energy, fluid balance, clotting, and the production of white blood cells.

Fats consist of fatty acids and glycerol and are essential for tissue growth, insulation, energy, energy storage, and hormone production. Each gram of fat provides nine calories. While some fat intake is necessary for energy and the absorption of fat-soluble vitamins, excess fat intake contributes to heart disease and obesity. Due to its high-calorie content, a little fat goes a long way.[4]

Fats are classified as saturated, unsaturated, and trans fatty acids. Saturated fats come from animal products, such as butter and red meat (e.g., steak). Saturated fats are solid at room temperature. Recommended intake of saturated fats is less than 10% of daily calories because saturated fat raises cholesterol and contributes to heart disease.[5]

Unsaturated fats come from oils and plants, although chicken and fish also contain some unsaturated fats. Unsaturated fats are healthier than saturated fats. Examples of unsaturated fats include olive oil, canola oil, avocados, almonds, and pumpkin seeds. Fats containing omega-3 fatty acids are

3. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0
4. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0
5. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0

considered polyunsaturated fats and help lower cholesterol levels. Fish and other seafood are excellent sources of omega-3 fatty acids.[6]

Trans fats are fats that have been altered through a hydrogenation process, so they are not in their natural state. During the hydrogenation process, fat is changed to make it harder at room temperature and have a longer shelf life. Trans fats are found in processed foods, such as chips, crackers, and cookies, as well as in some margarines and salad dressings. Minimal trans-fat intake is recommended because it increases cholesterol and contributes to heart disease.[7]

Choosing Food Groups to Meet Macronutrient Needs

Good resources for healthy nutritional choices are the USDA's "My Plate" guidelines.[8] By using a plate as a visual, sections on the plate illustrate general amounts of the different types of food groups that should be eaten every meal, including fruits and vegetables, grains, protein, and dairy. See Figure 6.1[9] for an image of the USDA's "My Plate" guidelines.

6. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0
7. This work is a derivative of Nursing Fundamentals by Chippewa Valley Technical College and is licensed under CC BY 4.0
8. MyPlate.gov. (n.d.). *What is MyPlate*? U.S. Department of Agriculture. https://www.myplate.gov/eat-healthy/what-is-myplate
9. "MyPlate_blue.png" by USDA is licensed under CC0

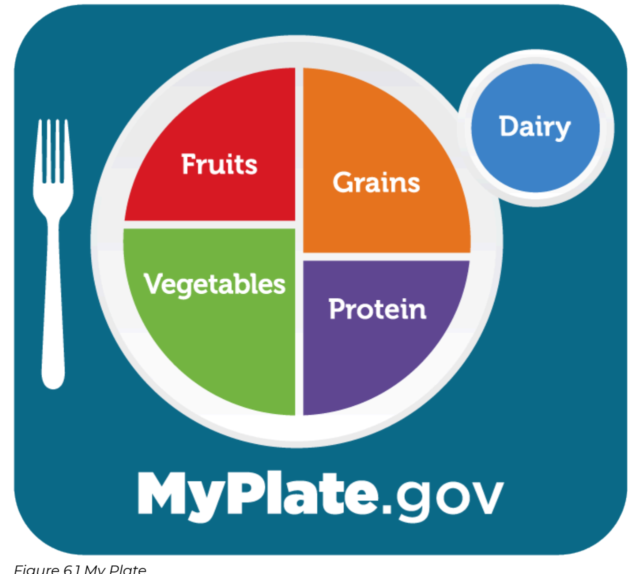


Figure 6.1 My Plate

About half the plate should be fruits and vegetables that provide many nutrients, as well as fiber for healthy bowel elimination. Fruits and vegetables are low in fat and calories and have no cholesterol. Fresh fruits and vegetables are the best choice, but frozen options have similar nutritional value. Frozen produce can also be more cost-effective because it doesn't spoil and can save time as the food is already cleaned and chopped. A variety of colors of fruits and vegetables not only makes the plate visually appealing, but also provides the greatest array of nutrients.

About 25% of the plate should be grains. Pasta, cereal, and bread are sources of grains. Types of grains include wheat, corn, rice, oats, barley, and quinoa. Grains are low in fat and cholesterol but have high carbohydrate and fiber content. The fiber content in grains can be helpful in preventing constipation and lowering cholesterol. Due to the high carbohydrate content of grains, they may need to be limited for clients with diabetes.

The remaining 25% of the plate should contain protein sources. Common proteins include soy, quinoa, eggs, fish, meat, nuts and seeds, legumes (beans), and dairy products. Just as with the other food groups, a variety of protein selections provides the most nutrients. Red meat can contain a lot of fat and cholesterol, so lean cuts are preferred for heart health. Fish, especially salmon, has healthy fat and should be consumed twice weekly. Nuts, seeds,

and legumes are low in saturated fat and high in fiber, which also make them a good choice for protein.

Dairy choices are important for calcium intake that aids in bone health. Calcium intake is important for older adults because they naturally retain less calcium and are at higher risk for bone fractures. Dairy products include milk, lactose-free milk, soy milk, buttermilk, cheese, yogurt, and kefir. Sour cream and cream cheese are not considered dairy items in terms of nutritional benefits. Adults should consume about three cups of dairy per day.

Choosing whole foods that are unprocessed, or as close to their original form as possible, is important to feeling full and stabilizing blood sugar because it takes longer to digest unprocessed foods. Think about eating an apple as compared to drinking apple juice. The whole apple will take a long time to chew and chemically break down to chyme, whereas the juice is ready to move through the digestive tract immediately. Eating whole foods can also reduce salt, fat, and sugar intake because they have no additives and can keep blood pressure, blood sugar, and cholesterol levels lower.

- Read additional information about My Plate guidelines at https://www.myplate.gov/.

Fluid Intake

Fluid intake comes from both liquids and foods. For example, most fruits and vegetables contain a lot of water, so they contribute to fluid intake. See Table 6.2[10] for water content in various foods.

Table 6.2 Water Content in Foods

10. This image is a derivative of “Table 3.1 Water Content in Foods” by University of Hawai‘i at Mānoa Food Science and Human Nutrition Program and is licensed under CC BY-NC-SA 4.0

Percentage	Food Items
90-99	Nonfat milk, cantaloupe, strawberries, watermelon, lettuce, cabbage, celery, spinach, squash
80-89	Fruit juice, yogurt, apples, grapes, oranges, carrots, broccoli, pears, pineapple
70-79	Bananas, avocados, cottage cheese, ricotta cheese, baked potato, shrimp
60-69	Pasta, legumes, salmon, chicken breast
50-59	Ground beef, hot dogs, steak, feta cheese
40-49	Pizza
30-39	Cheddar cheese, bagels, bread
20-29	Pepperoni, cake, biscuits
10-19	Butter, margarine, raisins
1-9	Walnuts, dry-roasted peanuts, crackers, cereals, pretzels, peanut butter
0	Oils, sugars

The average fluid intake in adults per day is 1.5 liters of fluids with additional 700 milliliters (mL) of water gained from solid foods. About 2.5 liters of fluid are excreted daily in adults in urine, feces, respiration, and other body fluids like sweat and saliva.[11]

There is some debate over the amount of water required to maintain health. There is no consistent scientific evidence proving that drinking a particular amount of water improves health or reduces the risk of disease. Additionally, the amount of fluids a person consumes daily is variable and based on their climate, age, physical activity level, and kidney function.[12]

11. Human Nutrition by University of Hawai‘i at Mānoa Food Science and Human Nutrition Program is licensed under CC BY 4.0
12. Human Nutrition by University of Hawai‘i at Mānoa Food Science and Human Nutrition Program is licensed under CC BY 4.0

Our bodies are constantly trying to balance our fluid volume using the physiological mechanisms of thirst and urine output. The "thirst center" is contained within the hypothalamus, a portion of the brain that lies just above the brain stem. As people age, their thirst mechanism becomes less responsive, causing a higher risk of dehydration. See Figure 6.2[13] for an illustration of the thirst response. Thirst occurs in the following sequence of physiological events:

- Receptors in the kidney, heart, and hypothalamus detect decreased fluid volume or increased sodium concentration in the blood.
- Hormonal and neural messages are relayed to the brain's thirst center in the hypothalamus.
- The hypothalamus sends neural signals stimulating the conscious thought to drink.
- Fluids are consumed.
- Receptors in the mouth and stomach detect mechanical movements involved with fluid ingestion.
- Neural signals are sent to the brain and the thirst mechanism is shut off.[14]

13. "Regulating-Water-intake-.jpg" by Allison Calabrese is licensed under CC BY 4.0. Access for free at https://pressbooks.oer.hawaii.edu/humannutrition/chapter/regulation-of-water-balance/
14. Human Nutrition by University of Hawai'i at Mānoa Food Science and Human Nutrition Program is licensed under CC BY 4.0

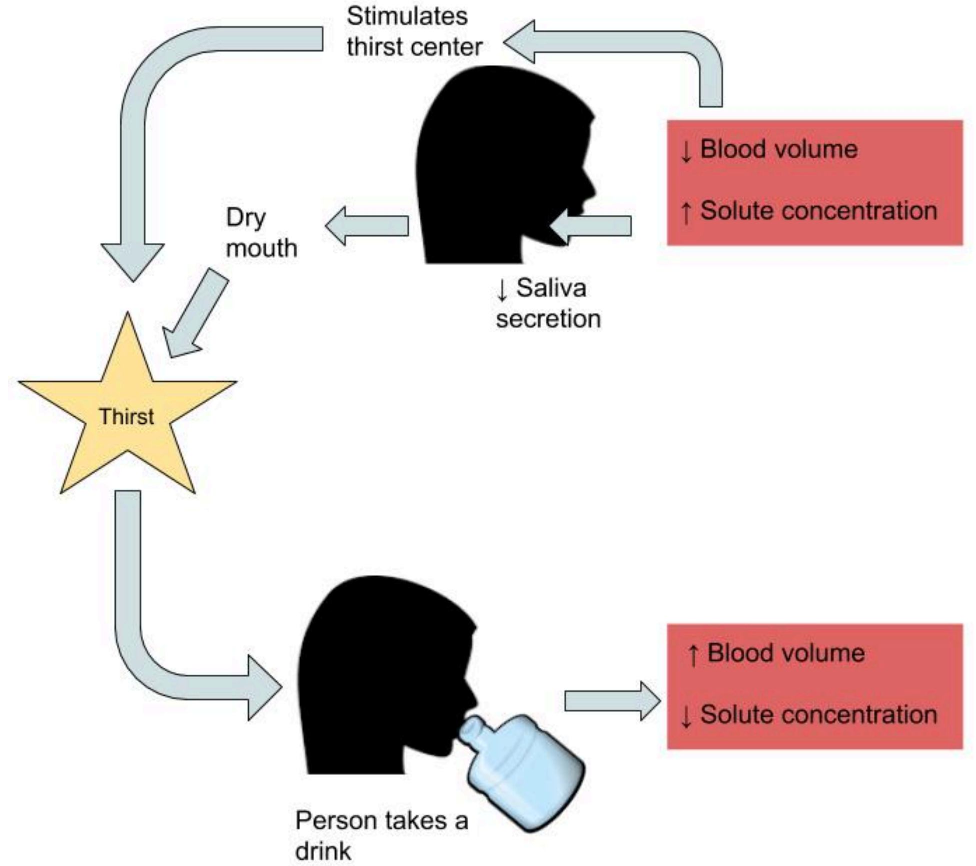


Figure 6.2 Thirst Response

Thirst is a subconscious physiological mechanism to stimulate water intake. However, actual fluid intake is controlled by conscious eating and drinking habits that are influenced by cognitive, social, and cultural factors. For example, some individuals have a habit of drinking a glass of orange juice, coffee, or milk every morning before going to school or work. Conversely, older adults often have decreased fluid intake due to physical or cognitive challenges in obtaining or drinking fluids. For this reason, older adults often require assistance to maintain a healthy intake of fluids.

Due to the decreased thirst response in older adults, it is important to prevent dehydration by encouraging fluid intake even when they don't feel thirsty. Dehydration can lead to confusion, falls, and bladder infections. Signs of dehydration include the following[15]:

15. Human Nutrition by University of Hawaiʻi at Mānoa Food Science and Human Nutrition Program is licensed under CC BY 4.0

- Dry mouth or other mucous membranes
- Dry skin or skin that does not return to normal shape when gently pinched
- Dark urine or urine amounts smaller than 200-300 mL
- Headache
- Dizziness
- Rapid heart rate
- Low blood pressure

If signs or symptoms of dehydration are noted, these concerns should be reported to the supervising nurse, and fluid intake should be encouraged as tolerated.

In hospitals and long-term care facilities, dieticians often determine the amount of daily fluid intake for clients. Fluid restrictions may be prescribed by the health care provider based on the client's medical condition. Fluid restrictions are further discussed in the following "Modified Diets" subsection.

Cultural and Religious Considerations With Nutritional Intake

Cultural and religious beliefs often influence a client's food selection and food intake. Dieticians and nurses assess a client's cultural and religious preferences on admission to a facility, but NAs should continually ask clients about their food and fluid preferences. A particular diet should never be assumed based on a client's stated culture or religion.

Cultural beliefs may affect the types of food eaten, as well as when they are eaten. Some foods may be restricted due to cultural beliefs or religious rituals, whereas other foods may be viewed as part of the healing process. For example, some individuals choose not to eat pork because of cultural or religious beliefs that consider pork unclean. Other individuals choose to eat "kosher" food because its method of preparation fits with their religious guidelines. Additionally, some individuals avoid eating during certain times. For example, some clients' religious beliefs encourage fasting on religious